DOCUMENT RETURNE

ED 154 573 EC 110 320

AUTHOR	Hughes, Gerald E.
TITLE	Professional Continuing Education Demonstration Project on Child Abuse and Neglect: An Evaluation of the Effectiveness of Unit 14 of the "We Can Help" Curriculum for Health Professional. Final Report.
INSTITUTION	American Academy of Pediatrics, Evanston, Ill.
SPONS AGENCY	National Center on Child Abuse and Neglect (DHEW/OHD), Washington, D.C.
PUB DATE	1 Nov 77
GRANT	90-C-866
NOTE	178p.; Print is marginal and may not reproduce well in hard copy
EDRS PRICE	MF-$0.83 HC-$10.03 Plus Postage.
DESCRIPTORS	*Child Abuse; *Curriculum Development; *Curriculum Evaluation; Health Personnel; *Inservice Education; Physicians; Professional Training; Workshops

ABSTRACT

The report describes activities of the American Academy of Pediatrics under a 1-year grant to evaluate the effectiveness of a child abuse curriculum for physicians and other health professionals. It is explained that the evaluation was conducted through a series of eight workshops based on the curriculum materials. Project results are reported in the following sections: comments on separate curriculum modules, comments on supplementary materials, profile of participants, examination of gains in participant knowledge and attitude scores from pre- to post-test, changes in participant behavior related to workshop attendance, and evaluation of the workshop program as a whole. Inclusion of prevention and treatment modules is recommended. Among 15 appendixes are a roster of legal resource persons and a sample workshop participant questionnaire. (CL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED154573

This report was prepared for:
U.S. Department of Health, Education, and Welfare
Office of Human Development
Office of Child Development
Children's Bureau
National Center on Child Abuse and Neglect

Under Grant No. 90-C-866
Karen Mitchell
Grant Project Officer

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

PROFESSIONAL CONTINUING EDUCATION DEMONSTRATION PROJECT ON CHILD ABUSE AND NEGLECT: AN EVALUATION OF THE EFFECTIVENESS OF UNIT 14 OF THE "WE CAN HELP" CURRICULUM FOR HEALTH PROFESSIONALS

Final Report
November 1, 1977

By American Academy of Pediatrics
Department of Educational Affairs
Evanston, Illinois

Gerald E. Hughes, M.D.
Project Director

Laurene S. Hughes, M.A.
Project Administrator

Assisted by Charles Reichardt and Diane Koller
Statistical Consultants
Northwestern University
Evanston, Illinois

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Laurene Hughes

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM."

EC110320

TABLE OF CONTENTS

SECTION I. Background..... 1
Incidence of Child Abuse and Neglect..... 1
Consequences of Child Abuse and Neglect..... 2
Role of the American Academy of Pediatrics..... 4

SECTION II. Methodology..... 6
Organizational Responsibilities/Staffing..... 6
Planning Conference..... 6
Target Participants..... 7
Selection of Task Force..... 8
Selection of Workshop Sites..... 8
Task Force Meeting..... 9
Selection of Legal Resource Persons..... 12
Publicity..... 12
Institutional Exhibit..... 12
Research Design..... 13
Issues to be Addressed in Evaluation of NCCAN Curriculum Unit 14..... 13
Development of Questionnaires..... 14
Statistical Procedures..... 16
Course Registration..... 16
Resource Materials..... 17
Comparison and Control Groups..... 17
Preliminary Evaluation of Training..... 17
Seminar at the Academy's Spring Session..... 18
Liaison..... 18
Proposed Future Directions..... 18

SECTION III. Methodological Problems/Considerations..... 20
Receipt of Curriculum..... 20
Materials Evaluated..... 20
Recruitment of Participants..... 20
Audio-Visual Materials..... 21
NIAS Site-Visit..... 21
NCCAN Dissemination of the Curriculum Prior to Evaluation..... 21
Threats to Validity..... 22

SECTION IV. Discussion..... 26
NCCAN Curriculum Materials..... 26
Non-NCCAN Curriculum Materials..... 32
General Remarks on Questionnaire Results..... 33
Profile of Participants and Description of Control Groups..... 38
Change in Participant Knowledge..... 56
Change in Attitude..... 69
Change in Behavior..... 70

SECTION V. Conclusion..... 76
Overall Comments on the Curriculum and Workshop Sessions..... 76
Suggested Curriculum Revision for Minority Populations..... 80
Recommendations for Improving Quality of Treatment Services..... 81
Reservations or Cautions About Use of the Curriculum..... 83
Comments on Use of Curriculum Materials for Training Physicians..... 88
Comments on Physical Facilities..... 85

SECTION VI. Summary..... 87

LIST OF TABLES

1. District VI Interest in Attending a Child Abuse and Neglect Workshop..... 35

2. Interest of Fellows in Attending a Child Abuse and Neglect Program Compared with Preregistrants and Participants..... 36

3. Returned Pre- and Post-questionnaires..... 37

4. Subspecialties of Physician Participants and Control Groups..... 39

5. Type of Practice in which Participants and Control Groups are Engaged..... 40

6. Number of Individuals Under Respondent's Supervision..... 42

7. Length of Time in Practice..... 43

8. Participant Responsibilities Related to Child Abuse..... 43

9. Legal Accountability for Child Abuse Activities..... 44

10. Mean Scores on Subsections of Objective Knowledge Test..... 45

11. Mean Responses on Opinion Items..... 47

12. Mean Responses to Characteristics Used to Describe Abusive Parents..... 49

13. Mean Responses to Characteristics Used to Describe Abused Children..... 51

14. Obstacles to Identifying, Referring and Treating Child Abuse..... 53

15. Most Important Problems Regarding Child Abuse and Neglect Faced by Respondents..... 57

16. Gains on Objective Test of Knowledge..... 62

17. Mean Self-Ratings and Gains on Knowledge and Confidence in Various Activities..... 63

18. Mean Self-Ratings and Gains in Knowledge of Various Topics Related to Child Abuse..... 64

19. Mean Self-Ratings and Gains in Understanding of Various Organizations' Roles..... 65

20. Mean Self-Ratings and Gains in Confidence to Perform Various Activities..... 66

21. Summary of Responses to Follow-up Telephone Interview..... 76

22. Evaluation of Curriculum and Training Program..... 77

23. Respondent Comments on Training Materials and Trainers..... 78

24. Participants' Opinion of the Usefulness of the Training Material..... 79

25. Usefulness of the Training Materials for Various Populations..... 81

26. Suggestions for Improving Quality of Medical Treatment for Families..... 82

27. Methods for Improving Continuing Education..... 83

TABLE OF APPENDIXES

A. Roster of Steering Committee Members

B. Letter to Task Force Nominees

C. Roster of Task Force Members

D. Supplementary Audio-Visual Material Reviewed

E. Roster of Legal Resource Persons

F. Letter to District VI Fellows

G. Workshop Participant Questionnaire

   1. General Pretest
   2. Content Pretest
   3. Post-test

H. Module Evaluation Form

I. Telephone Interview Format

J. Brochure Publicizing Course Schedule

K. Proposal for Competing Extension Grant

L. Statement from Minutes: Council on Child Health

M. Comments on "Behavioral Indicators of Abused Children"

N. Revised Outline: Legal Aspects of Child Abuse and Neglect

O. Curriculum Utilization Summary

SECTION I

BACKGROUND

Some children have always been abused and neglected. Infanticide and abandonment have been condoned by many societies as methods of population control. Injuries have been inflicted on children to drive out evil spirits, to please certain deities, to maintain discipline, and to inculcate ideas.[1] In recent times, Western society has disapproved of the deliberate, severe treatment of children. However, only within the past decade have all states in this country passed laws which require abusive and neglectful practices to be reported.

In 1946 Dr. John Caffey[2] described children with multiple fractures of the long bones in association with subdural hematomas. He developed a diagnostic tool which has made physicians more aware that maltreatment of children must be considered a possible cause of certain types and clusters of injuries. A paper which introduced the term "battered child syndrome"[3] was presented by Dr. C. Henry Kempe and associates at the 1961 annual meeting of the American Academy of Pediatrics. This paper focused the nationwide attention of medical professionals on the alarming problem of child abuse and neglect.

Incidence of Child Abuse and Neglect

The actual incidence of child abuse and neglect in the United States is unknown. Reported data are incomplete, and estimates vary considerably. One estimate is that 1% of all children in the United States are reported abused or neglected

---

1. Helfer, R.E., and Kempe, C.H., ed.: The Battered Child, ed. 2. Chicago: University of Chicago Press, p. xv, 3-19, 1974.

2. Caffey, J.: Multiple fractures in long bones of infants suffering from chronic subdural hematoma. Amer. J. Roentgenol., 56:163, 1946.

3. Kempe, C.H., Silverman, F.N., Steele, B.F., Droegemueller, W., and Silver, H.K.: The battered-child syndrome. J.A.M.A., 181:17, 1962.

annually.[4] The U.S. Department of Health, Education, and Welfare estimates that the actual incidence is more than one million annually.[5] Another recent estimate is 110,000 instances of physical abuse annually (500 instances per million population).[6] Approximately 80 to 85% of these injuries are inflicted on the skin (e.g., bruises, lacerations, burns), bones (e.g., fractures), and internal organs (e.g., hematomata; 10% are sexual abuse; and 5% are failure to thrive because of nutritional deprivation.[6] One study showed that about 10% of all types of trauma seen in children less than 6 years old brought to hospital emergency rooms results from suspected abuse.[7] Approximately 25% of all fractures in children less than 2 years old are believed to have been inflicted.[8] Estimates on the number of instances of neglect range from double to triple those of abuse.[6]

Consequences of Child Abuse and Neglect

Approximately 2,000 children in the United States die each year as a result of abuse.[9] Dr. Rowine Hayes Brown has written:

> "Child abuse victims are of special medical significance because approximately 10% of those hospitalized for their injuries will die. Many others may be left mentally or physically retarded as a result of their injuries, and may ultimately become charges upon our already overcrowded state and private institutions. When one considers the annual cost of keeping

---

4. Helfer, R.E., and Kempe, C.H., ed.: Child Abuse and Neglect: The Family and the Community. Cambridge, Massachusetts: Ballinger Publishing Company, p. xvii, 1976.

5. Ibid.

6. Schmitt, B.D.: Personal communication, 1977

7. Holter, J.C., and Friedman, S.B.: Child abuse: Case finding in the emergency department. PEDIATRICS, 42:128, 1968.

8. Kempe, C.H.: Pediatric implications of the battered baby syndrome. Arch. Dis. Child, 46:28, 1971.

9. Kempe, C.H., through Schmitt, B.D. Personal communication, 1977.

a child in such an institution, the economic ramifications of child abuse are evident."[10]

Results of research on the consequences of physical abuse include a 1962 study of 302 children in 71 hospitals; 11% of the children died and 28% had permanent brain damage/injury.[11] In another study Gregg and Elmer[12] found that, of 30 abused children, 42% were developmentally retarded and 76% were medically neglected. These children were compared to 83 child accident victims, of whom 18% were developmentally retarded and 13% were medically neglected. At Los Angeles County Hospital, a 50% reinjury rate was noted after the initial abuse,[13] and a 60% reinjury rate was found in a retrospective study conducted by British researchers in 1969.[14] Results of a 3 year follow-up of 42 abused children showed that 30% functioned at a retarded level, 43% had neurologic damage, and 28% had little or no developmental improvement from the time of abuse to follow-up. This lack of improvement was caused by significant brain damage in seven children, by psychosis in one child, and by minimal or inappropriate intervention to seven children.[15] Martin, et al.[16] studied 58 children who had a mean testing interval of 4.5 years. Of these, 5% were microcephalic, 31% had

---

10. Brown, P.H., Fox, E.S., and Hubbard, E.L.: Medical and legal aspects of the battered child syndrome. Chicago-Kent Law Rev., 50:45, 1973.

11. Kempe, C.H., Silverman, F.N., Steele, B.F., Droegemueller, W., and Silver, H.K.: The battered-child syndrome. J.A.M.A., 181:17, 1962.

12. Gregg, G.S., and Elmer, E.: Infant Injuries: Accident or abuse? PEDIATRICS, 44:434, 1969.

13. Ebbin, J., Gollub, M.H., Stein, A.M., and Wilson, M. G.: Battered child syndrome at the Los Angeles County General Hospital. Amer. Dis. Child., 118-660, 1969.

14. Skinner, A.E., and Castle, R.L.: Seventy-eight Battered Children: A Retrospective Study. London: National Society for Prevention of Cruelty to Children, 1969.

15. Martin, H.P.: The child and his development. In Kempe, C.H., and Helfer, R.E., ed.: Helping the Battered Child and His Family. Philadelphia: J.B. Lippincott Company, pp. 93-114, 1972.

16. Martin, H.P., Beezley, P., Conway, E.F., and Kempe, C.H.: The development of abused children. Part I. A review of the literature. In Schulman, I., ed.: Advances in Pediatrics, Vol. 21. Chicago: Year Book Medical Publishers, p. 25-73, 1974.

height and weight below the third percentile, and 53% had neurologic abnormalities (of which 31% were judged moderate to severe).

The work of the physicians cited here and their colleagues from many disciplines paved the way for passage of PL 93-247, The Child Abuse Prevention and Treatment Act of 1974.[17]

Role of the American Academy of Pediatrics

The Academy has long recognized that abuse and neglect is a major, unsolved health problem of children. Numerous articles on the subject have been published in the Academy's journal, PEDIATRICS. The Academy's Committee on Infant and Preschool Child drafted statements on the problem in 1966 and 1972.[18,19] The chairman of the Subcommittee on Child Abuse and Neglect of the Committee on Infant and Preschool Child testified at the 1973 hearings in support of PL 93-247,[20] which had incorporated many of the recommendations made in the Academy's statements. A priority activity of the Subcommittee had been to obtain funds for development of curriculum materials on child abuse and neglect for practicing physicians and physicians-in-training. The Committee could not secure funding for this purpose; however, it developed a self-instructional, audio-cassette program on child abuse and neglect which has proved highly effective in training physicians and other professionals.[21]

---

17. Public Law 93-247 (January 31, 1974): Child Abuse Prevention and Treatment Act, 93rd Congress, S. 1191.

18. Committee on Infant and Preschool Child. Maltreatment of children: The physically abused child. PEDIATRICS, 37: 377, 1966.

19. Committee on Infant and Preschool Child: Maltreatment of children--the battered child syndrome. American Academy of Pediatrics Newsletter (Suppl.): Vol. 23, February 1, 1972.

20. Allen, J.E.: Hearings Before the Subcommittee on Children and Youth of the Committee on Labor and Public Welfare, United States Senate, 93rd Congress: First Session on S. 1191. Washington, D.C.: pp. 157-161, 1973.

21. Committee on Infant and Preschool Child. A Self-instructional Program on Child Abuse and Neglect. Available from R.E. Helfer, M.D., Michigan State University, East Lansing, Michigan.

In 1973 the Academy was awarded a grant from the Bureau of Health Services, Research, and Evaluation, to conduct a descriptive study of nine health-based programs in child abuse and neglect.[22]

This report describes Academy activities under a 1-year grant from the National Center on Child Abuse and Neglect (NCCAN) to evaluate the health component of the multidisciplinary curriculum developed through Section 4 (a) (1) of PL 93-247. Curriculum effectiveness was defined in the grant priority statement as the extent to which trainees experience (1) an increase in knowledge in the content areas addressed, (2) attainment of desirable attitudes toward identifying and following up instances of suspected abuse or neglect, and (3) changes in skills/behavior (i.e., delivery of services) as a result of changes in the first two variables.

Another aspect of the evaluation is to recommend to NCCAN methods of curriculum dissemination and utilization shown to be effective or methods the evaluator believes would be effective.

The evaluation was conducted through a series of 1-day workshops based on the curriculum materials. These workshops were held in eight Midwestern cities from February 2 through May 24, 1977. A seminar using the model agenda and workshop trainers was also presented at the Academy's Spring Session in New Orleans, Louisiana, on April 17, 1977.

---

22. Task Force of the Committee on Infant and Preschool Child: A Descriptive Study of Nine Health-Based Programs in Child Abuse and Neglect. Evanston, Illinois: American Academy of Pediatrics, 1974.

SECTION II

METHODOLOGY

Organizational Responsibilities/Staffing

The American Academy of Pediatrics delegated the child abuse project to its Department of Educational Affairs. The Assistant Director of the department served as Project Director, with administrative responsibilities undertaken by a full-time Project Administrator whose salary was funded through the grant. Guidance on project administration also was obtained from a Steering Committee for the child abuse project, which was composed of representatives from the Academy's Department of Committees (including the Committee on Infant and Preschool Child) and Department of Chapters and Membership. Valuable support was provided by the Academy's District VI Field Service Representative and the Assistant to the Project Administrator. A member of the Academy's Executive Board, the Chairman of District VI, was also on the Steering Committee. The chairman of this Committee was a pediatrician and family practice physician who had previously been chairman of the Subcommittee on Child Abuse and Neglect of the Infant and Preschool Child Committee (See Appendix A for a list of these individuals and their titles.)

Planning Conference

The Steering Committee met for a planning conference in Chicago on August 20, 1976. Members reviewed the original grant proposal and recommended the following changes in the scope of work:

--expansion of the training session for Task Force members (workshop trainers) from 2 to 3 days,

--shortening the nine District VI workshops from 2 days to 1 day,

--change in composition of the Task Force, to consist only of Academy Fellows (FAAP's),

--expansion of the size of the Task Force to include one representative per state chapter in District VI, as well as one representative from each of the eight other Academy districts, and

--composition of the target audience.

These changes were subsequently approved by the NCAAN Project Officer.

The Steering Committee defined its responsibilities as:

--developing the role of Task Force members,

--defining the composition of the Task Force,

--nominating potential Task Force members,

--participating with the Task Force in review and evaluation of the NCAAN Unit 14 curriculum materials,

--determining the target area for the workshops,

--identifying potential workshop participants, and

--screening supplementary materials for possible inclusion in the workshops.

The Steering Committee elected to conduct a series of workshops within District VI, a nine-state area in the upper Midwest, for the following reasons:

--To make best use of the available funds, focus of the project was limited to one Academy District, rather than scattering training activities nationwide.

--A Field Service Representative position was created in the Department of Chapters and Membership through a pilot program established by the Academy's Executive Board. This staff person would be available to work with chapter officers and members to generate interest in the workshops and provide follow-up support.

--The District VI Chairman was supportive of the project in his district.

--The Director of the Department of Chapters and Membership cited a high level of interest in this type of training program among state chapter chairmen of District VI.

Target Participants

The Steering Committee determined that the following groups would be invited to attend the workshops (in descending order of priority):

--Academy Fellows,

--pediatricians who are not Academy Fellows,

--family practice physicians,

--pediatric residents,

--emergency room physicians,

--pediatric nurse practitioners/associates,

--emergency room nurses.

Selection of Task Force

The Steering Committee decided that a task force of pediatricians should be nominated who would constitute:

--an advisory body regarding implementation of the action steps of the grant,

--a knowledgeable cadre of trainers for the series of 1-day workshops,

--a group of trained resource persons and child advocates in their communities.

The Task Force would be composed of one pediatrician representing each Academy district other than District VI and one pediatrician from each Academy state chapter within District VI. The Steering Committee suggested names of possible Task Force members from each of the areas. District and chapter chairmen were then approached for their nominees, whom they were asked to rank in order of their preference. A letter (Appendix B) was sent to the preferred candidates. A week later all candidates were called to determine their availability and interest. All but one preferred nominee accepted the invitation to participate. (A roster of Task Force members is given in Appendix C.)

Selection of Workshop Sites

The sites for the nine 1-day workshops for physicians in District VI were selected by the Academy chapter chairmen. They were:

--St. Louis Children's Hospital, St. Louis, Missouri;

--University of Kansas Medical School, Wichita, Kansas;

--University of Iowa Hospital, Oakdale, Iowa;

--Loyola University Medical Center, Maywood, Illinois*;

--Childrens Memorial Hospital, Omaha, Nebraska;

--Children's Hospital, Milwaukee, Wisconsin;

--Children's Health Center of Minneapolis, Minnesota**;

--Dakota Hospital, Fargo, North Dakota;

--McKennan Hospital, Sioux Falls, South Dakota.

Task Force Meeting

The Task Force met in Evanston, Illinois, December 12 to 14, 1976, to accomplish the following:

--evaluate the Unit 14 curriculum modules and select supplementary materials on child abuse and neglect,

--plan the nine 1-day workshops to be conducted in District VI, and

--submit pre- and post-test questions.

After reviewing the Unit 14 material (Section IV), the Task Force decided to prepare a 1-day model agenda using the best materials from the curriculum and appropriate, supplementary audio-visual aids (Appendix D).

---

* The original site was Children's Memorial Hospital, Chicago.

**The original site was the University of Minnesota Hospital, Minneapolis.

MODEL AGENDA:

DISTRICT VI CHILD ABUSE/NEGLECT WORKSHOPS

8:00 a.m.	Coffee	
8:15	Convene/Welcome/Introductions Background of Grant/Outline of Agenda	
8:30	"Diagnosis of Child Abuse and Neglect"	
	8:30-8:55	Introduction of Module I Slide-Tape: "Visual Diagnosis of Non-Accidental Trauma and Failure to Thrive"
	9:45-10:15	Filmstrip: "Sexual Abuse"
	10:15-10:45	Discussion of Audio-visual Aids
10:45-11:00	Break	
11:00-12:00	"Observation of the Behavior of Parents and Children" (vignettes to be chosen by each team of leaders)	
12:00 p.m.	Lunch	
	12:20-12:35	Introduction and Lecture
	12:35-1:05	Film: "The Medical Interview"
	1:05-1:35	Discussion
1:35	Development of an Evaluation Plan	
	1:35-1:45	Preparation for Small Group Activity
	1:45-2:25	Small Group Planning
	2:25-2:50	Presentation and Discussion of Small Group Plans
2:50-3:00	Break	
3:00-3:30	"Legal Context of Child Abuse and Neglect" (lecture)	
3:30-4:00	Film: "The Medical Witness"	
4:00-4:30	Discussion of Legal Issues	
4:30-4:45	Post-test	
4:45-6:15	Local Issues (e.g., panel discussion with social worker, lawyer), supplementary materials (e.g., audio-visual aids, bibliographies) Discussion	

A number of supplementary materials were reviewed at the December 1977 Task Force meeting and subsequently for inclusion in the workshops. The District VI Task Force representatives presented the following position paper to explain their rationale for deleting approximately one-half the Unit 14 curriculum and for substituting other materials for the weaker portions of the NCCAN curriculum:

> "Although there are several good parts of the NCCAN curriculum, we feel that Unit 14 must be rejected as a comprehensive training guide in child abuse because of its poor quality.
>
> "We will, however, field test the select few parts that we find acceptable.
>
> "We also feel obligated to select from supplementary materials those items that will allow us to present a comprehensive program to our fellow physicians.
>
> "There is still a need for development of a comprehensive curriculum in child abuse and neglect."

The Task Force decided to present the nine workshops as both an evaluation excercise and a continuing education program.

Teams of workshop leaders were assigned according to their site preferences, with each pair having flexibility to choose the materials in the model agenda they wanted to emphasize. The leaders then developed the following training schedule:

--February 11, 1977	St. Louis, Missouri Drs. Dreher/Hebeler
--February 12, 1977	Wichita, Kansas Drs. Rubin/Carithers
--February 25, 1977	Oakdale, Iowa Drs. Solomons/Friedman
--March 2, 1977	Maywood, Illinois Drs. Newberger/Allen
--March 19, 1977	Omaha, Nebraska Drs. McIntire/Schmitt
--April 22, 1977	Milwaukee, Wisconsin Drs. Bond/Wethers

--May 4, 1977 — Minneapolis, Minnesota
Drs. Cress/Scheurer

--May 6, 1977 — Fargo, North Dakota
Drs. Reiser/Palmer

--May 24, 1977 — Sioux Falls, South Dakota
Drs. Heinrichs/Bartlett

Selection of Legal Resource Persons

Names of local legal resource persons for each workshop site were provided by an attorney who drafted the child abuse and neglect model state reporting statute. These persons (listed in Appendix E) were asked to present Modules 6 and 7 of Unit 14.

Publicity

A letter of invitation (Appendix F) was sent via first class mail in an Academy envelope by the District VI Chairmen to the 1,872 Academy Fellows in the District (except Canadian and emeritus members). A franked, return interest card was included with the letter. There are few Fellows in North and South Dakota, so family physicians were invited to attend workshops in those states.

Articles publicizing the award of the grant appeared in News+Comment, the Academy's monthly newsletter, and in the Bulletin to AAP Chapter Chairmen.

Institutional Exhibit

An institutional exhibit publicizing the grant activities at the Academy's Annual Meeting in Chicago, October 15 through 21, 1976, included a map indicating the workshop sites, a copy of the curriculum materials, some NCCAN publications on child abuse and neglect, and several handouts. A separate room was secured for a continuous showing of the audio-visual curriculum materials and other pertinent, commercially available audio-visual aids. Evaluation forms were given to viewers.

Research Design

Consultation was obtained on the research design and methodology from the Northwestern University Center on Research and Evaluation, Evanston, Illinois; from the University of Pennsylvania Hospital Institute Physician Education Project, Philadelphia, Pennsylvania; from the Oakland Children's Trauma Center, Oakland, California; from the National Institute for Advanced Studies, Washington, D.C.; and from a private research methodology consultant from Evanston, Illinois. Northwestern University also provided computer services through Vogelback Computer Center.

Issues to be Addressed
In the Evaluation of NCCAN Curriculum Unit 14

The seven areas outlined here are the major issues addressed in this study:

I. Profile of workshop participants
   - A. Subspecialty
   - B. Age
   - C. Type of practice (office-based, hospital-based, academic)
   - D. Practice setting (urban, rural)
   - E. Clientele (socioeconomic group, involvement with minority populations)
   - F. Number of years in medical practice
   - G. Previous training in child abuse and neglect
     1. During medical school
     2. In continuing education programs
   - H. Previous experience in working with families suspected of abusing/neglecting their children
     1. Number of suspected cases encountered in past 12 months
     2. Number of court appearances to testify as a medical witness in past 12 months

II. On the basis of data collected from control groups and from other research data, do the workshop participants constitute a representative sample
   - A. Of District VI Fellows?
   - B. Of Fellows outside District VI?
   - C. Of physicians in the United States?

III. Were there changes in participant knowledge, attitudes, or behavior as a result of workshop attendance?
   - A. Knowledge
     1. Diagnosis
     2. Interview of parents
     3. Observation of behavior of parents and children

4. Development of an evaluation plan
5. Legal aspects
6. Appearance as a medical witness in court

B. Attitude
C. Behavior

IV. In which of the areas listed in III above were participant gains the greatest?

V. Which participants benefited most from the course, in terms of the variables introduced in I?

VI. How did trainers and participants evaluate each of the Unit 14 NCCAN curriculum modules (corrections, additions, deletions recommended)?

VII. How should future training activities be conducted?

A. To whom should training be directed?
B. Who should do the training?
C. How should the sessions be conducted?
1. Sponsorship/auspices
2. Setting
3. Program (content areas, materials)
4. Length of training course
5. Publicity
6. Registration
7. Evaluation
8. Revision/adaptation

Development of Questionnaires

Pre- and post-questionnaires (Appendixes G-1, G-2, and G-3) were developed with assistance from the consultants listed here and with input from Academy staff from the Department of Educational Affairs. Each Task Force member at the December 1977 meeting submitted two objective questions per module, based on the curriculum materials. Curriculum effectiveness, which the Academy was contracted to measure, could be defined in two ways: (1) in relation to the goals stated in the curriculum itself, or (2) according to what Task Force members considered minimum knowledge to be gained by physician participants in a 1-day workshop on child abuse and neglect. Task Force members decided to include, as pre- and post-test questions, basic material on child abuse and neglect which, in their judgment, was missing from the NCCAN curriculum.

Each set of questionnaires had three parts: pretest, content pretest, and post-test. The pretest was designed for mailing to pre-registrants and for completion before the workshop. Part B of the pretest collected demographic data. Information about participants' attitudes toward working with abusive and neglectful families, and participants' self-rated knowledge and confidence of procedures germane to child abuse and neglect was gathered in part A. The content pretest (part C) was administered at the beginning of each session.

The questions were developed as described in the previous paragraph. Part C tested participants' knowledge of procedures and techniques in an objective format, and it served as an adjunct to the self-ratings in this topic area recorded in part A. The post-test was a composite of parts A, C, and D (part D was designed to measure the trainee's evaluation of the workshop as a whole). The post-tests were distributed after the session, and participants were asked to complete them before leaving. Those unable to complete the post-tests at that time were given adressed, franked envelopes and were asked to return the form as soon as possible. Participants were also asked to complete a narrative critique of each portion of the curriculum (Appendix H). The content of the questionnaires is illustrated in Figure 1.

Questionnaire items were grouped according to the general topic areas in Figure 1 and were then subdivided into specific knowledge areas. Gains in participant knowledge were measured by self-report in narrative evaluations of each module (questions 166 to 168) and by the difference in pre- and post-test scores on content items (questions 88 to 127). Changes in attitudes were also measured by self-report (questions 178 to 180) and by differences in pre- and post-test scores for questions 1 to 41 and 55 to 62. Intended behavioral changes were reported in questions 181 to 183. Follow-up telephone interviews were conducted with some participants 2 to 4 months after the workshops to determine whether there had been behavioral changes as a result of the sessions (Appendix I).

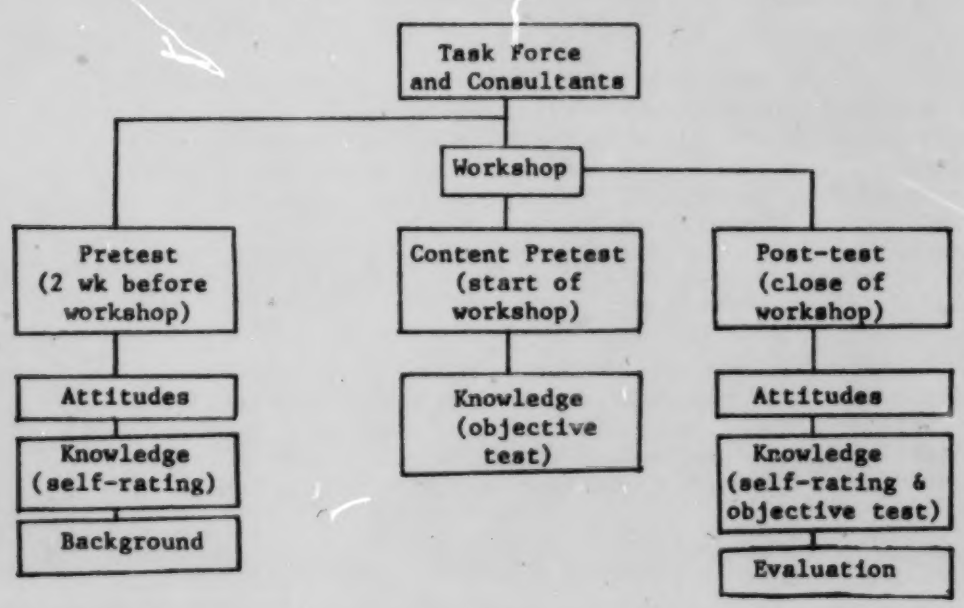

FIGURE 1 - Questionnaire summary

Statistical Procedures

The bulk of the results of this study are reported in terms of three inferential statistical indices; the t-test (t), chi-square coefficient (χ^2), and correlation coefficient (r). A brief elementary definition of these terms is presented; for more detailed discussion, see the report by Hays.[23]

The t-test as used here measures whether two mean values are equal. Thus, comparing pre- and post-test means using the t-test reveals whether or not a statistically significant change has occurred during the elapsed period of time. The chi-square test measures the degree of association between two categorically measured variables, e.g., whether age is related to attitudes. If measurements of both age and attitudes are categorized into several intervals (e.g., all those between ages 30 and 40 years), a chi-square test will indicate whether attitudes tend to differ from one age level to the next. The correlation coefficient measures the degree of linear relationship between two variables. For example, age and attitudes could be correlated to determine if attitudes change in a systematic, linear fashion according to age. A correlation of -1.0 means there is a perfect negative relationship between the variables. A correlation of 0.0 indicates there is no linear relationship. A correlation of 1.0 means there is a perfect positive linear relationship between the two variables.

Course Registration

A brochure (Appendix J) was mailed to the 400 Fellows who had indicated interest in attending one of the sessions, to family practice physicians in the Dakotas, and to District VI hospitals (to the emergency room staff and directors of continuing medical education). Family practice credit was obtained for the North Dakota course. All pediatricians who attended the course received a statement of eligibility for 9 hours of Category I credit for the AMA Physician's Recognition Award.

Registration was conducted through the Academy's Central Office. Rental of equipment, arrangements for food service, and contacts with representatives of the media were handled through local resource persons at each site, usually through the hospital department of continuing medical education.

---

23. Hays, W.L.: Statistics for the Social Sciences, ed. 2.: New York: Holt, Rinehart, and Winston, 1973.

Resource Materials

Pre-registrants received the pretest and resource papers 2 to 3 weeks before each session. Each participant at the workshops received a packet containing an instruction sheet, the agenda, the content pretest, the evaluation forms, the curriculum resource materials, the state child abuse and neglect reporting law, and a complimentary copy of Child Abuse and Neglect: The Family and the Community from Ross Laboratories.[24] Within two weeks after each workshop, participants received a statement of eligibility to receive AMA credit, as well as supplementary materials which included a detailed bibliography, model statute for termination of parental rights, protocol for handling suspected abused or neglected children in a hospital setting, and guidelines for follow-up of a child who has been sexually molested.

Comparison and Control Groups

At the December 1977 meeting of the Task Force, one member volunteered to use the physician participants in a Pennsylvania statewide multidisciplinary workshop on child abuse as a comparison group. This workshop was held April 12 and 13, 1977.

Two random sample control groups were identified: the first from inside District VI and the second from all other Academy districts combined. The purpose of these surveys was to provide summary data on members of the Academy so the workshop participants could be compared to those populations. For the District VI sample, every tenth Fellow (excluding workshop participants) and every workshop pre-registrant who did not participate received the pretest and content pretest. This group represents 16% of the Fellows in District VI. For the random sample outside District VI, every hundredth name was selected. Control groups received a cover letter explaining the project, the prequestionnaires, and a franked, addressed, return envelope.

Preliminary Evaluation of Training

On February 23, 1977, after completion of the first two workshops, the Steering Committee met with the research methodology consultants and Task Force representatives from St.

---

24. Helfer, R.E., and Kempe, C.H., ed.: Child Abuse and Neglect: The Family and the Community. Cambridge, Massachusetts: Ballinger Publishing Company, 1976.

Louis, Missouri, and Wichita, Kansas, to discuss the first two sessions and plan for the forthcoming meetings. It was decided that the model agenda would be the basis for the remaining workshop sessions, but minor revisions (e.g., supplementary materials, shortened activities) would be permitted and would be carefully documented for evaluation purposes. Future plans for training physicians about child abuse and neglect were discussed, including a possible continuing education course, a round table, or a seminar to be held at the Academy's 1977 Annual Meeting or at a meeting sponsored by one or more Academy chapters or districts.

Seminar at the Academy's Spring Session

A 1-day seminar based on the model curriculum was presented at the Academy's Spring Session in New Orleans, Louisiana, on April 17, 1977. The seminar was publicized through an article in the Academy's newsletter, through an advertisement in PEDIATRICS, and through notices in continuing medical education course brochures. Letters were also sent to pediatricians who signed the mailing list at the Annual Meeting exhibit and to other physicians from outside District VI who had indicated interest in attending such a training program. Two members of the Task Force and an attorney experienced in the field served as trainers at the session, which drew 18 participants (15 physicians) form all districts.

Liaison

Throughout the grant period, the Academy has shared its NCCAN and other resource materials with such organizations as the Juvenile Protective Association, Chicagp; Child and Family Advocates of Evanston, Illinois; Children's Memorial Hospital, Chicago; Metropolitan Area Protective Services, Chicago; Evanston Hospital, Evanston, Illinois; Northwestern University, Chicago; and Evanston Baby-Toddler Nursery, Evanston, Illinois.

Proposed Future Directions

Members of the staff working on the grant met with the Committee on Infant and Preschool Child on May 19 and 20, 1977, to discuss drafting a proposal to implement the recommendations for developing a revised curriculum (Appendix K).

At its June 18, 1977 meeting, the Council on Child Health endorsed the principle of continued Academy involvement in developing a model curriculum on child abuse/neglect for

physicians (Appendix L). The Council recommendation was forwarded to the Academy's Executive Committee for review and approval. The Academy's proposal for a 1-year competing extension grant to revise NCCAN Unit 14 was submitted on August 1, 1977.

SECTION III

METHODOLOGICAL PROBLEMS/CONSIDERATIONS

Receipt of Curriculum

A 3-month delay in receiving the curriculum resulted in postponement of some grant activities, particularly the 3-day training session for the Task Force originally planned for the first quarter of the grant period. This meeting had to be rescheduled for the second quarter, causing a heavier workshop schedule than expected during the third quarter.

Materials Evaluated

One limitation of the methodology is that only Unit 14 materials recommended for physicians in the introduction to that unit were reviewed and evaluated. An exception was Module III, which deals with observing parent and child behavior. The Steering Committee and Task Force decided this subject should be included in the agenda. However, Modules IV and V, which involve case planning and case monitoring, were not evaluated because they were intended primarily for public health and school nurses and nonphysician hospital personnel.

The 1-day agenda allowed insufficient time to include presentation of any material from the core curriculum. In retrospect, it might have been helpful to include selected materials on neglect and emotional maltreatment from Units IV and V.

Recruitment of Participants

Recruitment for the sessions was a problem, partly because of the postponement of the Task Force meeting; this caused a delay in publicizing the dates and sites of the session far enough to advance to attract many participants. It is necessary for physicians, particularly for those in private practice, to receive notice of this type of program 3 to 4 months in advance so that they can adjust patient appointment schedules. The large number of returned interest cards, 21.4% (400/1,872) of the District VI membership, indicates a much higher level of support than is reflected in the advance registration, 8.4% (158/1,872), and participant, 6.7% (126/1,872) figures. (Most preregistrant cancellations were from private practitioners who, with only several days' notice, were unable to leave their clinics or offices.) It is advisable to send several first-class mailings in Academy envelopes, with a cover letter signed

by the district or chapter chairman. The following groups should be invited to attend future workshops: pediatricians who are not Fellows, family practice physicians, emergency room physicians, surgeons, orthopedists, radiologists, osteopathic physicians, and nurses. As additional incentive, continuing education credit should be sought for each of these groups. Other recommendations for recruitment and selection of an appropriate site are discussed in Section V.

Audio-Visual Materials

The many types of media used in this training package make it difficult to obtain, set up, and operate the equipment. Filmstrips should be converted into 2" x 2" slides, particularly because filmstrip projectors have been the most difficult piece of equipment to obtain. Each of the accompanying cassettes should indicate that the reverse side of the tape is equipped with an audible signal to advance the slides.

Members of the Steering Committee and Task Force objected strongly to the idea that the Unit 14 audio-visual aids are being made commercially available in their present, unrevised condition.

NIAS Site-Visit

The Steering Committee expressed disappointment that representatives from the National Institute for Advanced Studies did not choose to site-visit any of the Academy workshops. The Committee felt that the additional data gathered from such a visit would have been helpful in assessing the effectiveness of both the curriculum materials and the workshop sessions.

NCCAN Dissemination of the Curriculum Prior to Evaluation

Steering Committee and Task Force members considered NCCAN's decision to make the preliminary version of the curriculum available for dissemination and marketing through the Regional Resource Centers prior to field testing and revision to be contrary to the purposes for which the evaluation grants had been let.

Threats to Validity

The primary mode of analysis used to measure the effectiveness of NCCAN curriculum Unit 14 was to compare participant pre- and post-test scores on knowledge and attitude items and to conduct follow-up telephone interviews with some participants. (See Section II for a more detailed discussion of the research design.) Possible threats to validity of the data include the following: (1) the element of chance, (2) testing effect, (3) events intervening between the pre- and post-tests, (4) whether the sample population is representative of the pool from which it was drawn, (5) questions included in the questionnaire, (6) difficulties posed by pooling the groups of workshop participants and analyzing the data as one group, and (7) difficulties introduced as a result of combining a curriculum evaluation process and a continuing education course. To view these potential biases in proper perspective, each of the rival hypotheses is discussed in turn.

Apart from the impact of the curriculum, one possible explanation for gains in test scores is that, in behavioral science research, responses can be expected to change slightly over time, or two variables will be related to some extent purely by chance. A respondent who is not sure of an answer may guess an item on the pretest. If the correct response is still unknown at the time of the post-test, the response again may be made largely at random. Participants are not likely to guess the same response both times if they did not remember the first random response. Therefore, the average (mean) response on the pretest would be expected to differ slightly from the mean response on the post-test purely by chance.

Inferential statistics were used to evaluate the probable contribution of chance as a factor in the observed changes. Given a set of assumptions, statistical calculations indicate how likely a result is to occur if it were caused solely by chance. If this probability (reported as a p level) is small enough, (less than .05 or .01 by convention), the observed difference or relationship is considered "real" in the sense that it probably could not be attributed to chance alone.

Another potential bias could be the result of the testing process. After completing the pretest, participants may have become sensitive to some issues or may have pondered implications of issues which could produce changes on the post-test, irrespective of any curriculum influence. There is no way to check directly on the extent of this possible bias, although there is no evidence to indicate that it has much influence.

Relevant events in addition to the workshop might have occurred between the time respondents completed pre- and post-questionnaires. For example, a newspaper exposé on child abuse

and neglect might have contributed to awareness, understanding, attitudes, or knowledge about child abuse. Irrespective of Academy-sponsored workshops, attitudes toward child abuse change over time because of shifts in public opinion. The factors described here could produce substantial changes in response from pre- to post-tests which could masquerade as effects of the curriculum.

The time elapsed between pre- and post-tests in the present study was minimized to reduce influence caused by time. Content pretests and the post-tests were designed for administration on the same day. However, retrieval of complete sets of questionnaires was difficult, especially gathering the postquestionnaires which were to have been returned by mail. Some respondents were rushed for time at the close of the workshop and asked if they could take the questionnaires to complete and return at a later date. Some participants (including on-site registrants) did not complete the general pretest before the workshop or did not remember to bring their completed tests. Some participants arrived too late to complete the content pretest before the workshop began. To speed the return of the general pretests and post-tests, duplicate copies of those forms were mailed to participants who had not returned them. This follow-up mailing brought in more than half of the missing pre- and post-tests. However, some of those who returned the pretests after the workshop probably did not complete them before attending the workshop. This would tend to obscure the real impact of the curriculum. Delay in returning the questionnaires also increases the likelihood that intervening events will masquerade as curriculum effects and increases the possibility of spurious differences in scores. Special attention should be directed to collecting as many completed sets of questionnaires as possible at future workshops before participants leave, so they will not have to be contacted for missing data. Continuing education credit should be withheld until all questionnaires have been received from a participant.

Fewer physicians attended the nine workshops than were anticipated, and the sample size was relatively small. The data from the sessions were collapsed and analyzed in one group rather than in the nine separate groups as originally planned. The smaller the sample size, the less power is attributed to the statistics, i.e., effects or relationships are not as clearly discernible as with larger samples. Trends are not as apparent with small samples; therefore, it is important to note that a great deal of credence was placed on self-reported gains in knowledge, attitude, and skills. Another issue related to the number of participants was difficulty in obtaining a comparison population of significant size. Questionnaires from the Pennsylvania group were analyzed separately, but it was difficult to draw meaningful conclusions because the sample size was not adequate.

Small populations may not constitute a representative sample. Also, potential bias exists because some participants failed to return the questionnaires. The opinions of individuals who did not return the forms may differ significantly from those of individuals who did return them. For example, participants who felt the program was not worthwhile and who did not profit from it may have felt less obligated to complete the questionnaires. Conversely, those who benefited most could have felt greater motivation to complete and return them. This bias resulting from self-selection may lead to an overestimate of curriculum effectiveness. However, it would not make a poor program appear beneficial, because it would be evident that at least some participants showed gains in their scores. There is no way to control the bias caused by self-selection; however, there is no reason to suspect that the effects of this bias are severe.

Attempts were made to determine whether the participant sample was representative by comparing it to control groups, within District VI, outside District VI, with data collected by Chang, et al.[25] in a 1973 study of physician attitudes on child abuse and neglect, and with data published in Health Resources Statistics.[26]

The questions selected for inclusion in the questionnaires also need to be considered because curriculum effects will only be apparent in topic areas where participants have been queried. It is also important to select topic areas of significance. Pages 14 through 15 describe how questionnaire items were selected and the steps taken to select appropriate test items. Trainers were asked to evaluate the questionnaire items; this resulted in discarding several inappropriate or poorly worded items. Question 70 is one example of poor wording; it asks the number of times during the past year the respondent has testified in court as an expert witness (a witness with special expertise recognized by the court). The question should have been more general, and it should have read "as a medical witness." As worded, the question may have had the effect of showing participants to be less experienced than they actually were.

---

25. Chang, A., Oglesby, A.C., Wallace, H.M., Goldstein, H., and Hexter, A.C.: Child abuse and neglect: Physicians' knowledge, attitudes, and experiences. Amer. J. Pub. Health, 66:1199, 1976

26. U.S. Department of H.E.W., Public Health Service, Health Services and Mental Health Administration, National Center for Health Statistics: Health Resources Statistics. Washington, D.C.: U.S. Government Printing Office, pp. 165-177, 1975.

Bias may also result from the attempt to combine an evaluation process with a continuing education course. This issue is mentioned on page 11, where the rationale is presented for combining the two activities. Because many of the curriculum materials were judged to be of poor quality, Task Force members were unwilling to conduct the evaluation sessions unless supplementary materials to produce an acceptable continuing education program for participants were included. The bias introduced by this combination of activities is a tendency to rate the curriculum materials more highly than they deserve.

Valid interpretation of the statistical procedures used requires that certain assumptions for each statistic be met (see Hays[27] for a detailed discussion of these assumptions). For the purposes of this report, the most critical of these assumptions involves use of the chi-square test. To have confidence in the accuracy of the reported p level of the chi-square test, every cell of the contingency table (i.e., the entries in the tabled categories) must contain at least five observations (e.g., individuals categorized in that cell). Because of the small sample size, this assumption is violated repeatedly, so the results of the chi-square tests should be interpreted only as rough guidelines.

There is no evidence to suggest that any of the alternative hypotheses mentioned here appreciably affected the data. They are raised only as issues to be considered in interpreting the data.

---

27. Hays, W.L.: Statistics for the Social Sciences, ed. 2: New York: Holt, Rinehart, and Winston, 1973.

SECTION IV

DISCUSSION

The report of the project results is presented in the following sections: comments on the separate curriculum modules; comments on the supplementary materials used; a profile of participants, including how they compare with the control groups and other populations studied; and examination of gains in respondent knowledge and attitude scores from pre- to post-test; changes in participant behavior related to workshop attendance; and evaluation of the workshop program as a whole.

NCCAN Curriculum Materials

The following comments are a composite of those made by (1) the Steering Committee and Task Force members, who reviewed all the Unit 14 materials; (2) the participants in the District VI workshops; and (3) the participants in the seminar conducted at the Academy's Spring Session. The last two groups reviewed the materials selected for inclusion in the model agenda developed by the Task Force and Steering Committee; the materials are indicated by an asterisk (*).

All filmstrips for the unit should be revised so (1) each frame displays a number corresponding to the script; (2) sound effects are eliminated; (3) "motion" slides postulating how injuries might have been inflicted are eliminated; (4) the technical aspects (e.g., lighting and color) of some frames are improved; and (5) the program is in a slide medium.

Module I. Diagnosis

No resources materials are provided for the 20-minute talk reviewing diagnostic aspects of child abuse, which means that the diagnostic section of Module I is of little value. One trainer recommended distributing a sample history in connection with the opening lecture.

Filmstrip 1--"Skin Injuries"

Filmstrip 1 provides a helpful review, but it is somewhat elementary for physicians. An outline of the script content would probably be a useful handout.

Filmstrip 2--"Internal Injuries"

Aspects of filmstrip 2 cited as most helpful were discussion of the more prevalent intra-abdominal injuries and dating of bruises. The narration rambles; it needs more concise

organization. The sound track, which is garbled in places, requires editing. Many photographs fail to enhance the text (e.g., shots of pensive children) and appear to be included more to manipulate the viewers than enlighten them. More young children need to be shown. Frame 110 displays a child's name, which should be blacked out. Frame 78 is backward; the liver is on the wrong side.

Filmstrip 3--"Skeletal Injuries"

Filmstrip 3 is too long, the X-rays are poorly reproduced, and the medical term "X-ray" is mispronounced. This material needs extensive revision.

Filmstrip 4--"Neglect"

Much important information on failure to thrive was omitted from filmstrip 4. It does not adequately stress the importance of weighing the child during examination, nor does it mention the advisability of offering the child the same diet as that provided at home. It is important to document that unit of weight gained in a given time interval. Healthy infants generally gain 1 to 2 oz. per day. Children who have failed to gain this amount at home but begin to do so in a controlled hospital setting may be diagnosed as having nonorganic failure to thrive. The filmstrip should also point out that, according to Barton D. Schmitt, M.D.,[28] failure to thrive in roughly one-fourth of the infants with this problem results from difficulty with the "mechanics" of feeding, one-half is caused by the deliberate withholding of food or provision of a grossly inappropriate diet, and one-fourth is attributable to organic causes. The filmstrip should comment on maternal and infant bonding and its relationship to neglect. It fails to point out that roughly 25% of children who fail to thrive are also abused. Filmstrip 4 should include a photograph of a child with dehydration. The issue of unintentional (cultural) neglect is not adequately discussed. The portion describing dental caries as a possible indicator of neglect is somewhat misleading and needs to be qualified.

*Filmstrip 5--"Sexual Abuse"

Viewers thought filmstrip 5 was well done. Even those who reported not learning anything new found the review well organized and well presented. Those who felt they gained information from it said they learned the following: doll play is useful to determine the child's vocabulary and enable interviewing in the

---

28. Schmitt, B.D.: Personal communication, 1977.

child's language; it is advisable to conduct only one interview, preferably by a physician of the same sex as the child; it is recommended that the parents and child be interviewed separately; and it is necessary that evidence of suspected sexual abuse be signed for in the lab because the findings may be submitted into evidence in criminal court proceedings. Respondents liked the narrator's comment that a child's response to sexual assault is largely dependent on the reaction of adults to the incident. Favorable remarks were also made about the preparatory steps for the necessary tests, including suggestions to maximize the comfort of the child during these procedures.

Other comments were that filmstrip 5 deals largely with sexual assault by nonfamily members rather than subtle findings such as occur in incestuous sexual molestation or fellatio. Materials need to be developed to help physicians explore those possibilities. Several viewers requested more information, such as resource papers, on the psychodynamics of families in which incest has occurred, on psychological reactions anticipated as a result of assault, on how to counsel the child, and on any possible coexisting pathologic or microscopic findings. Many frames do not illustrate the text. More anatomical photographs and factual materials should be presented visually. There is a statement that follow-up examinations need to be performed after 48 hours, after 2 to 3 weeks, and after 3 to 4 months, with no rationale for these recommended intervals. There should be a statement that it is advisable for the physician to discuss the child's emotional condition with the district attorney.

Questions raised in discussing filmstrip 5 included the following: How suspicious should the physician be of perineal tears (which parents frequently say are caused by constipation) or of vaginal discharges? Is it advisable to have a witness present during the physical examination or interview? What is known about the sexually provocative child? Does incest sometimes "occur" only in a child's fantasies? What should be the role of a physician when a teen-age patient becomes pregnant as a result of incest?

Other issues not covered in this filmstrip are normal demonstration of affection between parents and children, sexual play among children, ramifications of sexual abuse on adult sexual adjustment, and exploitation of children in pornographic media. A sample history would be a helpful resource to distribute with this filmstrip.

Many viewers expressed the need for training in child gynecology.

The slide presentation, "Medical Identification: Physician," from the National Institutes of Mental Health (NIMH) curriculum, "Focus: Child Abuse and Neglect," may be an appropriate

supplement to NCCAN Module 1. To date, the Academy has not had an opportunity to review it (Appendix D).

*"Development of an Evaluation Plan"

The "Alice" case study was considered too long and in need of substantial revision. Because it poses a believable problem and generates much discussion, a small-group exercise using a series of well written case histories was highly recommended as a teaching exercise. One suggestion was to show slides illustrating the case history under review. The leaders at several workshops presented case studies from their own experience rather than the "Alice" material. The model agenda shows the Task Force recommended including this exercise after Modules II and III had been presented.

The wall chart, "Facts About Child Abuse", accompanying Module I was extremely simplistic. One viewer commented that no one is free of feeling one or more of the items listed under #5 of the wall chart. He suggested adding the following underlined words to that statement: "They may be unable to cope with any of the following...."

Important aspects of diagnosis which are omitted from the NCCAN curriculum include a lecture outline for a presentation on local issues (such as incidence and source of reports), material on diagnosis of emotional abuse, deliberate poisoning, and rape. Discussion of long-range case outcome is not a principal goal of this activity, but it was suggested that such information be provided for the family under consideration.

The film, "Case Conference," from the NIMH curriculum, "Focus: Child Abuse and Neglect," (Appendix D) shows the role of a pediatrician in a multidisciplinary group (including parents) and discusses recommendations for placement of a child after release from the hospital. For the child under review, abuse has been established by the professional team, but the parents have not admitted it.

*Module II. "The Medical Interview"

Neither the resource paper nor the film specifically discussed an acute phase interview, the situation most frequently confronting a practicing pediatrician. Although the interview film is skillfully conducted, it does not reflect constraints imposed by a 15- to 20-minute office visit. Participants commented that they learned how to phrase nonaccusatory and open-ended questions, and they learned the importance of managing their hostile feelings toward the parents. Physicians must be able to deal with their own anger toward the parents because treatment will be most effective if the parents are cooperative. At least part of an acute phase interview with a parent probably will be conducted without the child present. Discussion

of this aspect of the interview is not included in Module II. The need to inform the parents that a report must be filed with the local protective services agency is not discussed in the film. The legal requirement to report an incident would have to be placed in the context of concern for the safety of the child and the well-being of the family. Perhaps it would be helpful to illustrate referral of a family by a private practitioner to a child protection team.

There are technical problems (rapid zoom, camera focus, indistinct audio) which distract from the content of the presentation. Another suggestion was that the film should consist of several different interviews, such as one with a family in which abuse or neglect is thought likely to occur in the future, an acute phase interview in which the physician tells the parents that the child is being admitted to the hospital, and an interview several days after the incident. The focus of the third segment would be on rehabilitation of the family.

Recommended supplementary materials include the film, "Initial Interview," from the NIMH curriculum, "Focus: Child Abuse and Neglect," which was reviewed since the workshop, and shows a well conducted acute phase interview in a hospital setting, as do the video tapes "Acute Phase, Pediatric" and "Acute Phase, Consulting Pediatrician." "High Risk Family" shows a self-referred family interview with a physician in an outpatient setting (Appendix D).

*Module III. "Observing the Behavior of Parents and Children"

In most workshops there was a 10- to 20-minute discussion of the resource papers, which had been mailed to pre-registrants several weeks prior to the session. Many participants regretted that more time was not devoted to psychosocial aspects of the problem. One reviewer cautioned that most data collected on this subject are retrospective and incomplete.

There are two apparently contradictory statements in the trainer's manual. Page 55 of the manual gives one of the goals of Module III as "to describe and demonstrate behaviors that may be observed in children and parents as they interact that may be indicative of maltreatment." Yet, on page 57 it says, "This module does not present observation techniques as a way of determining the presence or absence of abuse or neglect." Without learning these techniques, it would seem the former goal cannot be achieved.

The resource papers for Module III were thought to be more valuable than the vignettes, which were shown only at the first few workshops. Appendix M is a detailed critique of the resource paper, "Behavioral Indicators of Abused Children."

A major criticism directed at the papers is that they do not present the material developmentally. It is also important that a child's behavior be viewed in the context in which it occurs because situational factors will appreciably affect behavior (e.g., being in a hospital setting, number of strangers present, separation from parents, time of day).

The temperament of the child also needs to be considered in interpreting behavior. It is important for a physician to know as much as possible about the child's medical/developmental history. Another point which should be mentioned is the child's input into an abusive incident because the behavior of some children is especially irritating or prevocative.

A significant omission is discussion of cultural differences to which observers must be sensitive if they are to interpret the parent-child interaction accurately. There are no definitions given for the terms "mild," "moderate," and "severe," which appear throughout this material. The behavior of a child who has been a victim of chronic abuse (whether or not the child has been badly beaten) may be considerably different from that of a child who has experienced a single, traumatic episode. None of the vignettes depict the effects of clear-cut abusive or neglectful behavior toward children. Although they might be appropriate for generating discussion around parent-child interactions and behavioral problems, the vignettes have little correlation with child abuse and neglect. Film or videotape would be a more effective medium for illustrating the concepts involved. The chart, "World of Abnormal Rearing Cycle" developed by Dr. R.E. Helfer[29] would be appropriate supplementary material for this section.

*Module VI. "Legal Aspects of Child Abuse and Neglect"

The curriculum outline for Module VI is somewhat confusing. An attorney who wrote the model state reporting statute reworked the outline (Appendix N). Participants considered this the most valuable part of the program, largely because of the high caliber of the legal resource persons who presented it at the sessions. They learned details of their state reporting laws, roles of the juvenile and criminal courts, legal terminology, and that failure to diagnose and report instances of child abuse and neglect is grounds for a medical malpractice suit. Participants asked for a resource paper summarizing the key points of Module VI. They also felt more time should have been given to legal issues.

---

29. Committee on Infant and Preschool Child: A Self-instructional Program on child abuse and neglect, p. 1-2. Available from R.E. Helfer, M.D., Michigan State University, East Lansing, Michigan.

The filmstrip recommended for use with Module VI, "Issues in Reporting Child Abuse and Neglect," was simplistic and confusing. It was not shown at any of the workshops.

An important topic omitted from Module VI is the role of the guardian ad litem.

*Module VII. "The Medical Witness"

The film in Module VII might be offensive to physicians because of the actor who portrays the physician, but it generates immense discussion and points out numerous pitfalls during court testimony. The curriculum says that a legal resource person must be present to lead the discussion. Respondents learned about the exception made in the hearsay law for child abuse and neglect, the importance of detailed medical record-keeping, preparation for testifying in court, questions and tactics to be expected in direct and cross-examination, and the importance of maintaining composure during testimony. The narration was considered excellent. An outline summary of the narration was requested as supplementary material.

The film omits discussion of the role of guardian ad litem, which trainers need to discuss. It also misrepresents the level of preparation of the state's attorney, who is usually given a dossier only minutes before the trial. Use of photographs as evidence is not adequately covered. Photographs cannot be used to substitute for appearance of a witness. A witness must testify that a photograph is a true and accurate representation of the child on a particular day before it can be admitted as evidence. The question was raised whether doctors must inform parents that photographs which may be used as evidence are being taken of the child. (This varies from state to state.) Another issue with which trainers may want to familiarize themselves is who pays for such photographs.

The accompanying resource paper provides much valuable information not presented in the film.

The film, "Physician in Court," from the NIMH curriculum, "Focus: Child Abuse and Neglect," is recommended as an alternative to "The Medical Witness" (Appendix D).

Non-NCCAN Curriculum Materials

*Visual Diagnosis of Non-Accidental Trauma and Failure to Thrive" (to replace three NCCAN filmstrips on medical aspects)

This slide/tape presentation, developed by Barton D. Schmitt, M.D., of the University of Colorado Medical Center, was extremely well received. The sections on subdural hematoma, bone

injuries, and failure to thrive were cited as particularly helpful. General information was gained on clinical aspects of specific kinds of inflicted trauma (e.g., subdural hematomas as a result of shaking a child, injuries associated with toilet training or masturbation, stages of fracture remodeling over time) and on important historical data to collect from the patient and family.

Critical comments were that the slides showed the most blatant kinds of injuries and should include examples of less obvious (and therefore less easy to diagnose) forms of abuse and neglect. One respondent suggested that, for purposes of comparison, examples should be included of accidental injuries at the same sites. Many participants felt that too much material was presented too rapidly and that printed outlines summarizing the content should be provided. (These were included in postpackets mailed to participants.)

There was also a request for a sample history and for further discussion of taking a family history. More information was requested on differential diagnosis, including unusual child-rearing practices which appear to be abusive. Other requested that intra-abdominal injuries and head injuries be considered in greater detail, and that lab findings which might indicate inflicted injuries be discussed. A suggestion was made that the verbal instructions to advance each slide be substituted with a tone signal. One respondent, who found the information in this program well organized and helpful, suggested compiling a booklet based on the photographs and text. (Note: This material is available as an issue of Current Problems in Pediatrics, and it could be distributed to participants as resource material in connection with Module I.) The participants believed that this material should be given to all medical students.

Other Materials

At several workshops in Module II, only segments of the film, "The Interview," were shown; it was supplemented (at other sites replaced by) with one or more of these videotapes: "Acute Phase, Pediatric," "Acute Phase, Consulting Pediatrician," "High-Risk Family," "Schizophrenic Mother"/"Disturbed Parent-Child Relationship." The film, "Don't Give Up On Me," was also presented at one workshop (Appendix D).

General Remarks on Questionnaire Results

Despite attempts to standardize the curriculum, each of the nine sessions was unique. In addition to the inevitable variation in program content (Appendix O), there were also potentially significant differences among instructors and participants. To

control for variation among trainers, all instructors were Fellows experienced in child abuse and neglect. (See Section II for detailed presentation of methodology.)

The next concern in analyzing the data was to check on consistency of participant responses across the nine separate sessions to see whether there were significant differences among groups which ought to be pointed out before merging participants into one group. Few statistically significant differences were found among workshop groups in the background, attitude, knowledge, or evaluation sections of the questionnaires. The differences that were statistically significant were generally unimportant (e.g., the number of "excellent" versus "good" evaluations of how the training program was conducted.) The small sample size from each workshop may be responsible in part for the few differences among the nine populations and is also justification for combining all workshop participants into one homogeneous group for purposes of analysis.

Of the 1,872 Fellows in District VI who were initially contacted about their interest in attending one of the workshop sessions, 400 (21.4%) returned cards requesting further information about the program. The number of letters sent and the number and percent of cards returned from each state are given in Table 1.

The distribution of the 126 physician participants is shown in Table 2. The figures include only those who attended the entire workshop because these were the persons asked to submit data. Many medical students and residents (as well as emergency room staff and other health personnel) attended all or part of the course but were not asked to complete the tests.

Analysis of data collected was limited to physician questionnaires. As mentioned in Section III, some participants did not return all three parts of the questionnaire. Complete data were obtained from 66 physicians (52.4%) and only partial data from the other 60. In all, 108 general pre-tests, 93 content pre-tests, and 91 post-tests were returned. In the following analyses some items have fewer tabulated responses than the above figures indicate, because some persons did not respond to each item on the returned questionnaires. The number of physicians supplying complete and incomplete sets of data from each session is shown in Table 3.

TABLE 1

DISTRICT VI INTEREST IN ATTENDING A CHILD ABUSE AND NEGLECT WORKSHOP

Workshop Site	Preliminary Letters Sent	Interest Cards Returned	Interested in Program
St. Louis	283	50	17.7
Wichita	127	35	27.6
Oakdale	141	18	12.8
Maywood	750	113	15.1
Omaha	90	47	52.2
Milwaukee	229	57	24.9
Minneapolis	210	64	30.5
Fargo*	21	11	52.4
Sioux Falls**	21	5	23.8
TOTAL	1,872	400	21.4

* Session was cancelled.

**Registration handled by workshop leader rather than through AAP Central Office

TABLE 2

INTEREST OF FELLOWS IN ATTENDING A CHILD ABUSE AND NEGLECT PROGRAM COMPARED WITH PREREGISTRANTS AND PARTICIPANTS

Workshop	Total	Number of Interest Cards Returned Participants	Number of Interest Cards Returned participants	Number of Participants Interest Cards Not Returned	Number Pre-registered	Number of On-site Registrations	Total M.D. Attendance (excluding trainers)
St. Louis	50	10	40	2	20	2	12
Wichita	35	14	21	7	14	4	18
Iowa City	18	6	12	1	11	0	7
Maywood	113	16	97	3	22	0	19
Omaha	47	16	31	8	21	12	27
Milwaukee	57	6	50	2	13	0	8
Minneapolis	64	7	57	3	13	1	10
Sioux Falls	*5	0	4	10	25	1	10
Fargo	11	SESSION CANCELLED					
New Orleans Academy Spring Session		Not Applicable			19	0	15
TOTAL	400	86	322	36	158	20	126

*Preregistration handled by physician trainer.

TABLE 3

RETURNED PRE- AND POST-QUESTIONNAIRES

Workshop	Number of Complete Sets	Number of Incomplete Sets
St. Louis	6	6
Wichita	3	15
Iowa City	6	1
Maywood	16	3
Omaha	14	13
Milwaukee	8	0
Minneapolis	2	8
Sioux Falls	6	4
New Orleans (Academy's Spring Session)	5	10
TOTAL	66	60

Of the 1,872 Fellows in District VI, a total of 300 (10% who were randomly selected plus all preregistrants who did not participate in the workshops) received general and content pretests. This group represented 16% of the District VI membership. Eighty of these (26.6%) returned questionnaires (79 complete, 1 incomplete). This group was called the "in-district" control group.

One hundred forty-three Fellows, 1% of the Academy membership outside District VI, were randomly selected for the study. Of this "out-of-district" sample, 45 (31.5%) returned questionnaires (44 complete, 1 incomplete).

The full battery of questionnaires was administered to five physician participants in a Pennsylvania statewide workshop on April 12 and 13, 1977. Four of those five were returned. Because of the small size of this comparison population, it was difficult to obtain meaningful data.

Profile of Participants and Description of Control Groups

Three summary statistics will often be presented together in describing the respondents. The first of these numbers applies to workshop participants, the second to the in-district sample, and the third to the out-of-district sample. If a single statistic is given, it refers to the workshop sample, unless otherwise stated.

Of the 126 physicians who attended the workshops, 96% (96%, 100%) were engaged in medical practice. The remainder were medical students or residents. One hundred eighteen (93.7%) were pediatricians. Seven family practice physicians and one osteopathic physician account for the remaining 6.3%. Twenty-five of these 118 pediatricians (21.2%) had received training in pediatric subspecialty areas, as reflected in Table 4.

Most respondents were male (82%, 83%, 79%) and Caucasian (83%, 89%, 91%). Only 5% (1%, 2%) of the participants were black.

The age distribution was fairly even across the categories of 30-34, 35-39, 40-44, 45-49, and 50-59 years. The respondents had an average of 2.4 (2.7, 2.5) children of their own. Of the participants, 30.7% indicated they were in solo or small group practice; 24.5% (23.0%, 18.9%) were in academic medicine; 20.9% (28.7%, 22.6%) were in hospital-based practice. About 7.4% (4.6%, 3.8%) were involved in administration or delivery of services in federally funded programs; approximately 7% (4.6%, 3.8%) were involved with state or local programs, and roughly 9.2% provided medical consultation to such groups as health departments, school systems, and state crippled children's services (Table 5).

Respondents tended to work in large cities rather than in small towns or rural areas, a fact which is understandable considering the workshop sites selected. However, there was fairly even representation from areas with all degrees of population density.

TABLE 4

SUBSPECIALTIES OF PHYSICIAN PARTICIPANTS AND CONTROL GROUPS

Pediatric Subspecialty	Workshop Participants	In-district Sample	Out-of-district Sample	Pennsylvania Comparison
Adolescent Medicine	1		1	
Allergy		1	1	
Anesthesiology			1	
Cardiology	2	1	1	
Child Abuse/Neglect	1			
Child Development	2	1		
Child Psychiatry	3			
Community Pediatrics	2		1	
Developmental Disabilities	3			
Diabetes and Growth		1		
Endocrinology	1			
Genetics			1	
Handicapped Children		1		
Hemotology	1	1		
Immunology		1	1	
Infectious Diseases		1		
Neonatology	2	3	3	
Nephrology		1		
Neurology		1		
Nuclear Medicine	1	1		
Oncology			1	1
Public Health	5	2		
TOTAL	25/118 (21.2%)	17/299 (5.7%)	13/143 (9.1%)	¼ (25%)
M.D. Nonpediatricians				
Family Practice Physicians	7	1		1
Osteopathic Physicians	1			

TABLE 5

TYPE OF MEDICAL PRACTICE IN WHICH PARTICIPANTS AND CONTROL GROUPS ARE ENGAGED

Type of Practice	Workshop Participants	In-district Sample	Out-of-district Sample	Comparison Group
Private Practice				
Solo	17	22	13	1
Group/Clinic (incl. HMO)	33	16	16	1
	50(30.6%)	38(43.7%)	29(54.7%)	2(28.6%)
Hospital				
Practice				
Private	11	14	6	
Public	5	4	4	
Administration	6			
Teaching	12	7	2	1
	34(20.9%)	25(28.7%)	12(22.6%)	1(14.3%)
Academic Medicine				
Teaching/Supervision	27	15	8	2
Administration	7	4	2	2
Research	4			
In-Training	2	1		
	40(24.5%)	20(23.0%)	10(18.9%)	4(57.1%)
Government Programs				
Federal				
Administration	5	3	2	
Practice	7	1		
	12(7.4%)	4(4.6%)	2(3.8%)	
State				
Administration	8			
Practice	3			
	11(6.7%)			
Local				
Administration				
Practice	1			
	1(.6%)			
Consultation				
Health Department	9			
Crippled Children's	3			
School System	3	1		
	15(9.2%)	1(1.1%)		
TOTAL RESPONSES	163	87	53	7

In terms of the socioeconomic status of their clientele, the most frequently reported category was "lower middle class" (40%, 46%, 38%). The next most common responses were "lower income" and "upper middle class" (35% and 27% respectively for the workshop sample; 19% and 36% for the in-district sample; 29% and 31% for the out-of-district sample). In terms of racial and ethnic composition of the participants' client population, the majority were involved with Caucasians, although a significant number were also involved with black, Hispanic, and other groups. Two and one-half percent of the workshop sample serves populations which are 76 to 100% native American. Also of note is that 17.3% (3.0%, 9.1%) of the participants have "substantial involvement with military families" (Table 6).

Participants were rather evenly spaced across the categories for length of time in practice (Table 7).

Approximately half the respondents (49%, 60%, 47%) had received prior instruction in how to handle suspected child abuse and neglect during on-the-job training. Some had been exposed to the issues involved during their medical school or residency training (20%, 16%, 23%). Others had attended formal courses offered by employers (2%, 7%, 3%), employer-sponsored conferences or seminars (14%, 22%, 22%), or nonwork-affiliated seminars or conferences (27%, 30%, 26%). In general, previous training covered a broad range of topics on child abuse, particularly identification, reporting, and treatment rather than referral or case management. Virtually all (98%) of the participants volunteered to attend the Academy-sponsored workshop.

During the year preceding the workshop, 56% (65%, 58%) of the respondents had been substantially involved with between 1 and 10 instances of suspected child abuse and neglect. Sixty percent (65%, 58%) had reported between 1 and 10 instances during the past 12 months. Forty-seven percent (58%, 62%) had never appeared in court to testify as an expert witness; 49% (38%, 33%) had testified between 1 and 10 times.

The vast majority of participants have specific professional responsibilities in child abuse and neglect cases. Ninety-five percent (96%, 93%) see themselves as having responsibility for identifying child abuse; only 43% (43%, 33%) feel they have case management responsibilities (See Table 8).

A substantial number of respondents also believed their agency to be legally accountable for various activities related to child abuse and neglect, although many were uncertain of the specific aspects of that accountability. These figures are given in Table 9.

TABLE 6

NUMBER OF INDIVIDUALS UNDER RESPONDENTS'S SUPERVISION

Number of Persons Supervised	Workshop Participants	In-district Sample	Out-of-district Sample	Pennsylvania Comparison Group
0	21 (25.9%)	27(40.9%)	10(22.7%)	
1-5	24 (29.6%)	15(22.7%)	15(34.1%)	1(33.3%)
5-10	14 (17.3%)	12(18.2%)	6(13.6%)	
10-15	9 (11.1%)	2(3.0%)	1(2.3%)	
15-20	4 (4.9%)	1(1.5%)	2(4.5%)	1(33.3%)
20-30	5 (6.2%)	1(1.5%)	4(9.1%)	1(33.3%)
30-50	2 (2.5%)	4(6.1%)	4(9.1%)	
50-75			1(2.3%)	
75-100	1 (1.2%)	1(1.5%)		
100-150		1(1.5%)		
150-200			1(2.3%)	
200-250		1(1.5%)		
700	1 (1.2%)			
4000		1(1.5%)		
Number of Respondents	81 (64.3%)	66(25.8%)	44(30.8%)	3
Contact with Military Families	14 (17.3%)	2(3.0%)	4(9.1%)	1
Contact with Native American Families	2 (2.5%)			

TABLE 7

LENGTH OF TIME IN PRACTICE

Sample	1 year or less (%)	2-5 years (%)	6-10 years (%)	10-20 years (%)	More than 20 years (%)
Workshop	3.8	27.6	23.8	20.0	24.8
In-district	5.0	18.8	12.5	35.0	28.8
Out-of-district	2.2	26.7	24.4	11.1	35.6

TABLE 8

PARTICIPANT RESPONSIBILITIES RELATED TO CHILD ABUSE

Sample	Identification (%)	Reporting (%)	Referral (%)	Case Management (%)	Treatment (%)	Providing Court Testimony (%)
Workshop	95.2	90.4	71.2	43.3	48.1	62.5
In-district	96.1	85.7	70.1	42.9	45.5	50.6
Out-of-district	93.3	86.7	57.8	33.3	33.3	44.4

TABLE 9

LEGAL ACCOUNTABILITY FOR CHILD ABUSE ACTIVITIES

Sample	Reporting (%) Known/Unknown		Referral (%) Known/Unknown		Case Management (%) Known/Unknown		Treatment (%) Known/Unknown	
Workshop	47.5	47.5	41.0	48.0	33.0	49.5	32.3	48.5
In-district	38.5	52.6	33.8	53.2	24.7	53.2	26.0	53.2
Out-of-district	40.9	56.8	31.8	56.8	30.2	58.1	25.0	56.8

From the demographic data on the three sample populations, the similarity in responses of the groups is evident. The foregoing data would indicate that, apart from a slightly higher level of participant involvement with government-funded programs, the physicians who attended the workshops were representative of their district and of Fellows in other parts of the nation.

A few questions the instructors judged to be of poor quality had to be discarded from the objective test of knowledge. The remaining items were grouped into four content categories: (1) diagnosis/identification, (2) case management, (3) interviewing, and (4) legal aspects. Mean responses in each of these areas for the workshop pretest), in in district, and out-of-district samples are shown in Table 10. The number of questions (therefore the maximum possible individual responses) in each category is also given in Table 10. Using an analysis of variance, statistically significant differences between samples were found for responses to questions on identification ($F=4.28$, d.f.=2,241, $p=.015$), case management ($F=3.05$, d.f.=2,241, $p=.049$), and interviewing ($F=10.74$, d.f.=2,241, $p=.001$). Sample differences in response to questions on legal issues just missed the conventional level of statistical significance ($F=2.92$, d.f.,=2,241, $p=.056$). Nonetheless, as Table 10 shows, the differences in mean responses to knowledge items among samples are not significant. The workshop sample appears slightly more knowledgeable than the out-of-district sample,

which seems a little more knowledgeable than the in-district population.

TABLE 10

MEAN SCORES ON SUBSECTIONS OF OBJECTIVE KNOWLEDGE TEST

Category	Number of Items in Test Section	Workshop (pretest)	In-district	Out-of-district
Identification	9	5.70	5.291	5.477
Case Management	2	1.61	1.456	1.568
Interviewing	4	2.96	2.983	3.159
Legal aspects	10	6.16	5.693	5.386

Descriptions of respondent self-ratings on their level of knowledge concerning child abuse and neglect are given on pages 77-79. There were few apparent differences among responses of the participant (pretest), in-district, and out-of-district samples. Of 35 chi-square tests for differences on the items reported in Tables 17-20, only two reached conventional levels of statistical significance. From these data it was concluded that participants tested prior to the workshop sessions did not differ significantly from either control group in knowledge of issues about child abuse and neglect.

In one section of the questionnaires, respondents were asked to indicate whether they agreed with a number of opinions about child abuse. Responses were made on a five-point scale: 1 = strongly agree, 2 = agree, 3 = uncertain, 4 = disagree, 5 = strongly disagree. These statements and the mean responses for the workshop (both pre- and post-tests), in-district, and out-of-district samples are presented in Table 11. The following list of items was used to elicit the opinions for Table 11.

1. Society contributes to child abuse and neglect by expecting parents to nurture and support children with little or no training.

2. All parents can be considered potential child abusers.

3. Parents who physically abuse their children are mostly from lower socioeconomic levels.

4. Most cases of child abuse and neglect cannot be prevented.

5. In an interview with a parent suspected of child abuse and neglect, it is important for the social worker, physician, or health professional to focus the interview on the child rather than on the parent.

6. Health professionals are reluctant to admit to themselves that anyone, particularly a regular patient, could abuse a child.

7. Physicians often deny the existence of child abuse.

8. Mandatory reporting laws place the physician or health professional in a difficult position because they force him/her to violate the confidence of the patient in the privileged doctor-client relationship.

9. Reporting a suspected case of child abuse to the authorities is being responsive to the parent's plea for help.

10. The question of whether or not a particular child abuse case should be reported should be left to the discretion of the attending physician.

11. Unless conclusive evidence of abuse or neglect exists, reporting a suspected case of child abuse or neglect is an irresponsible act.

12. The difficulties involved in having to go to court contribute to underreporting of child abuse by physicians.

13. Courts should not be able to subpoena a physician's records in a child abuse case.

14. Children who have suffered abuse or neglect from their parents should be removed from the home permanently to prevent future physical or emotional trauma.

15. Parents who abuse or neglect their children should be prosecuted to the fullest extent possible.

TABLE 11

MEAN RESPONSES ON OPINION ITEMS

Question	Workshop Pretest	Workshop Post-test	In-district	Out-of-district
1	2.20	2.07	2.34	2.36
2	2.06	1.87	2.41	2.62**
3	3.29	3.41	3.62	3.62
4	3.82	3.89	3.81	4.04
5	3.61	3.46	3.66	3.64
6	2.37	2.30	2.49	2.67
7	2.55	2.54	2.66	2.53
8	3.55	3.61	3.22	3.51
9	2.16	1.95	2.27	2.40
10	3.93	4.04	3.84	3.60*
11	4.16	4.23	4.05	3.98
12	2.08	2.17	2.22	2.47
13	3.81	4.18	3.85	3.82
14	3.76	3.85	3.76	3.73*
15	3.73	3.88	3.61	3.58

* $p < 0.05$ on χ^2

** $p < 0.01$ on χ^2

The chi-square tests of differences among workshop (pre-test only), in-district, and out-of-district samples were statistically significant on the items marked with an asterisk (*). Even when the chi-square tests were statistically significant, the mean differences in responses among groups were small; and the samples did not differ significantly in response to these items.

Respondents were asked to select from a list of characteristics those which describe abusive parents they have encountered. These characteristics and their mean selection ratings are listed in Table 12, ranked from the least selected characteristic to the most frequently selected one. Chi-square tests of differences among the three samples (using only workshop pretests) were statistically significant on only the two items indicated by asterisks. The correlation among the three groups was 0.98, indicating that the mean responses are identically ordered in each sample.

Respondents also selected from a list of characteristics those describing most abused children with whom they had contact.

The sparsity of statistically significant chi-square tests (asterisks denote significant tests) points to the similarity in responses of the three groups. Among the workshop pretest and post-test, in-district, and out-of-district samples, the correlations of item sequence in Table 13 are 0.93, 0.91, and 0.96, respectively, confirming that there are few differences among the samples.

Respondents were then asked to rate the seriousness of certain obstacles to the identification, referral, and treatment of individuals who abuse or neglect their children. The rating scale was as follows: 0 = not applicable in my experience, 1 = not important obstacle, 2 = present, but not severe obstacle, 3 = serious obstacle. The items and responses appear in Table 14, which lists them in order from the obstacle judged least serious to the one considered most serious.

TABLE 12

MEAN RESPONSES TO CHARACTERISTICS USED TO DESCRIBE ABUSIVE PARENTS

	Characteristic	Workshop Pretest	Workshop Post-test	In-district	Out-of-district
1.	Trusts others	0	0.01	0	0
2.	Resourceful	0	0.01	0	0
3.	Socially active	0.01	0.01	0.01	0.04
4.	Tolerant of frustration	0.04	0.07	0	0
5.	Intelligent	0.08	0.06	0.06	0.09
6.	Motivated to change abusive behavior	0.10	0.16	0.09	0.09
7.	Overprotective of child	0.12	0.13	0.07	0.11
8.	Introspective	0.13	0.28	0.11	0.09
9.	Idealistic	0.17	0.18	0.11	0.11
10.	Will not allow child to be self-sufficient	0.28	0.32	0.16	0.18
11.	Psychotic	0.29	0.22	0.17	0.14
12.	Do not want children	0.38	0.49	0.36	0.41
13.	Self-destructive	0.44	0.45	0.32	0.27*
14.	Was never able to please parents	0.50	0.63	0.57	0.50
15.	Sees child as extension of self	0.54	0.58	0.49	0.44
16.	Anxious	0.56	0.61	0.37	0.43

* $p < 0.05$ on χ^2

TABLE 12 (Continued)

Characteristic	Workshop Pretest	Workshop Post-test	In-district	Out-of-district
17. Suppresses communication of feelings	0.69	0.73	0.61	0.48
18. Isolated	0.72	0.87	0.66	0.59
19. Has difficulty expressing needs	0.78	0.80	0.66	0.64
20. Views child's dependency needs as demands	0.79	0.79	0.75	0.64
21. Expects too much of his children	0.79	0.87	0.57	0.73**
22. Lacked nurturing in childhood	0.84	0.91	0.84	0.82
23. Abused by own parents	0.85	0.89	0.89	0.89
24. Feels inadequate	0.85	0.89	0.79	0.82
25. Impulsive	0.87	0.82	0.85	0.79
26. Immature	0.94	0.89	0.84	0.93
27. Experiences intense anger	0.95	0.87	0.90	0.89

** $p < 0.01$ on χ^2

TABLE 13

MEAN RESPONSES TO CHARACTERISTICS USED TO DESCRIBE ABUSED CHILDREN

	Characteristic	Workshop Pretest	Workshop Post-test	In-district	Out-of district
1.	Are very compulsive	0.14	0.20	0.11	0.14
2.	Are immobile	0.26	0.41	0.27	0.23
3.	Do not enjoy play activities	0.29	0.45	0.31	0.20
4.	Are extremely aggressive	0.32	0.35	0.11	0.18**
5.	Are extremely self-controlled	0.32	0.42	0.14	0.23*
6.	Have short attention span	0.33	0.43	0.26	0.20
7.	Are very dependent	0.38	0.39	0.32	0.39
8.	Have frequent temper tantrums	0.39	0.42	0.30	0.29
9.	Are very concerned about meeting parents' needs	0.45	0.64	0.40	0.39
10.	Are inordinately shy	0.52	0.71	0.30	0.48*
11.	Are extremely compliant	0.59	0.77	0.55	0.50
12.	Have a very poor self-concept	0.62	0.72	0.64	0.61

* $p < 0.05$ on χ^2

** $p < 0.01$ on χ^2

TABLE 13 (Continued)

Characteristic	Workshop Pretest	Workshop Post-test	In-district	Out-of-district
13. Are wary of physical contact	0.62	0.80	0.67	0.66
14. Are inhibited in verbal or crying response	0.68	0.64	0.59	0.57
15. Display generalized fearfulness	0.74	0.81	0.69	0.64

TABLE 14

OBSTACLES TO IDENTIFYING, REFERRING, AND TREATING CHILD ABUSE

Obstacle	Workshop Pretest	Workshop Post-test	In-district	Out-of-district
1. Believe it best to handle such problems alone	0.82	0.79	1.04	0.77
2. Believe reporting not part of professional responsibility	0.90	0.86	0.92	1.00
3. Believe few cases of child abuse and neglect occur in my community	0.92	0.86	0.88	0.93
4. Do not have adequate information on state reporting laws	0.92	1.02	1.11	1.00
5. Am uncertain what community response to such a report would be	1.01	1.25	1.34	0.91*
6. Am unwilling to accept sole responsibility for making report	1.12	1.11	1.40	1.18
7. Am unwilling to report middle- and upper-income families	1.13	1.28	1.12	1.02
8. Do not wish to breach confidentiality of privileged communications	1.15	1.30	1.44	1.27

* $p < 0.05$ on χ^2

TABLE 14 (CONTINUED)

Obstacle	Workshop Pretest	Workshop Post-test	In-district	Out-of-district
9. Fear liability for reporting	1.32	1.21	1.34	1.32
10. Feel community response to reports of suspected cases too punitive	1.32	1.18	1.39	1.25
11. Do not wish to destroy professional relationship with client/patient	1.43	1.53	1.50	1.29
12. Believe that those involved will be unjustly stigmatized	1.47	1.55	1.55	1.43
13. Believe that reporting is ineffectual; no help will be provided to the family	1.56	1.36	1.73	1.43
14. Am unwilling to testify in court	1.60	1.58	1.69	1.70
15. Object to time and paper work involved in reporting and following up	1.66	1.82	1.83	1.54
16. Fear making an unjustified report	1.89	1.66	2.01	1.98
17. Positive diagnosis of child abuse and neglect difficult	2.09	1.96	2.14	2.00

There are few statistically significant chi- square tests and correspondingly high correlations among the workshop pre-test and post-test, in-district, and out-of-district groups (0.94, 0.97, and 0.97, respectively).

Responses to the attitude portion of the questionnaire were remarkably similar across the three samples. Apparently the members of the Academy share opinions and attitudes about child abuse and neglect.

Table 15 summarizes participant responses to the pretest item asking what they considered the most serious problem (excluding treatment) related to child abuse and neglect. From the responses given, however, it was apparent that many did not concentrate on the question because they did not exclude treatment issues from consideration. Before the workshop, District VI participants were most concerned about diagnosis (30.1%), testifying in court (17.7%), prevention (16.8%), and getting help for treatment of the parents and child (11.5%). Other issues expressedin the narrative question were interagency referral (8.0%), relating to the parents (7.0%), dealing with resistant or negative attitudes toward reporting or working with the families (3.5%), reporting suspected abuse (2.6%), and problems with definitions, especially of emotional maltreatment and neglect (1.2%).

When demographic data from participant, comparison, and control groups were compared with statistics from other sources, it was apparent that the Fellows attending the sessions were a sample representative of U.S. physicians. The following summary of Tables 2 and 5 compares participant data with figures obtained from the American Medical Association[30], the National Center for Health Statistics[31], and the National Medical Association[32].

---

30. American Medical Association: Profile of Medical Practice, 1975-76. Chicago, Illinois, 1976.

31. U.S. Department of H.E.W., Public Health Service, Health Services and Mental Health Administration, National Center for Health Statistics: Health Resources Statistics. Washington, D.C.: U.S. Government Printing Office, pp. 165-177, 1975.

32. National Medical Association: 1974 Manpower Survey. Washington, D.C.: National Medical Association, 1974.

Category	Workshop Participants (%)	AMA (%)	National Center for Health Statistics (%)	NMA (%)
Federal physicians	92.6		92.9	
Office- based general practice	40.5	54.2		
Hospital- based practice	20.9	25.1	21.2	
Other (includes teaching, research, administration)	24.5	20.7	8.9	
Black physicians	5.0			1.1

Change in Participant Knowledge

Changes in knowledge and attitudes were measured by both objective and subjective questions. To interpret the data, it was necessary to decide on the emphasis to place on objective versus subjective items. The Academy chose to rely heavily on subjective reports of participant changes, especially where the gains were more strongly stated than they appear from examining the objective items.

Statistically significant gains in the mean number of correct responses were made in two areas on the objective test of knowledge.(diagnosis and legal aspects) but not in others (interviewing and case management). The complete results - including pre- and post-test means, number of respondents, number of test items, mean changes, t-tests, and probability levels - are presented in Table 16.

One possible reason that significant gains were not observed for items on interviewing is the few test questions covering that content area. Case management was discussed only briefly in the workshop because the Academy did not evaluate Unit 14 Modules IV and V, the principal modules in the unit dealing with those topics. Those two modules were not recommended for physicians; therefore, they were not included in the model agenda.

TABLE 15

MOST IMPORTANT PROBLEMS REGARDING
CHILD ABUSE AND NEGLECT FACED BY RESPONDENTS

Type of Problem	Workshop Participants	In-district Sample	Out-of-district Sample	Pennsylvania Comparison Group
Definition	1			
-of neglect	1			
-of emotional abuse	1			
-of sexual abuse	1			
-is too broad		1		
Percent responding	2.7%			
Prevention	12		2	
-would like to see a required high school course on child rearing	2	1		
-identification of high-risk groups	3	4	1	
-early recognition	1			
-especially of neglect	1			
Percent responding	16.8%	8.3%	12.9%	
Diagnosis	17	7	3	1
-of emotional abuse	7	1	2	
-of sexual abuse	4			
-of neglect	3	1		
-of subtle forms of abuse	1	3		
-as distinguished from culturally acceptable punishment	1			
-use a team approach to abuse is usually not brought to physician's attention by parent or child		1		
-failure to identify/ report suspected abuse in clinic under my supervision		1		
Percent responding	30.1%	23.3%	16.1%	25.0%

Table 15 (Continued)

Type of Problem	Workshop Participants	In-district Sample	Out-of district Sample	Pennsylvania Comparison Group
Attitudes				
-physician attitudes	1			
-admitting to myself it can occur in my practice		1		
-convincing and educating non physician professionals that abuse and neglect occur and of the need for management	1			
-educating other physicians (nonpediatricians) about the extent and nature of the problem	1			
-my disdain for the abuser is so intense that I cannot accept the notion of successful treatment and ultimate return to the parental home			1	
-my inability to comprehend how parents could abuse or neglect their children		1		
-public awareness	1			
Percent responding	3.5%	3.3%	3.2%	
Approaching parents	2	1		
-initial interview, dealing with own anger toward parents	3	4	1	
-discomfort in dealing with parents				1
-constructive ways to approach parents	1	1		
-ways to open discussion with parents without being threatening or inducing guilt	1			

TABLE 15 (Continued)

Type of Problem	Workshop Participants	In-district Sample	Out-of-district Sample	Pennsylvania Comparison Group
Approaching parents (continued)				
-communication with neglectful parents	1			
-keeping parent's confidence in me		3		
-counseling parents on marriage, child-rearing		4	1	
-inability to obtain information from father; mother is source of nearly all information			1	
Percent responding	7.0%	21.7%	9.7%	25.0%
Reporting	2	2		
-parent protection against losing the child after a report has been filed	1			
-confrontation with the parents			1	
-interim care of the child			1	
Percent responding	2.6%	3.3%	6.5%	
Referral	2	1	2	
-without damaging physician/parent relationship		1	1	
-identifying sources	1			
-reliability, responsibility of child protective services	1			
-communication among support agencies	3			
-custody/placement for children	1	1		
-determining how long families should be given to "rehabilitate" before petitioning for termination of parental rights	1			
Percent responding	18.0%	5.0%	9.7%	

TABLE 15 (Continued)

Type of Problem	Workshop Participants	In-district Sample	Out-of-district Sample	Pennsylvania Comparison Group
Getting help for parents and child	3			
-motivating parents to receive treatment			2	
-improvement of community services		1	1	
-developing comprehensive, coordinated community programs	1	1		
-apathetic social service system	1			
-coordinating multi-agency responsibility into a functioning system	1	3	5	
-shortage of trained social workers to care for an increasing case load		1	2	
-retention of case workers			2	
-social workers' lack of knowledge and experience about child abuse and neglect		2		
-insufficient foster care services			1	
-too many nonprofessional people involved		1		
-proper use of community resources	1	1		
-I am not informed of outcome		3	2	
-follow-up of sexual abuse cases	1			
-concern whether existing procedures are in child's best interest	1			
-developing best treatment plan	2			

TABLE 15 (Continued)

Type of Problem	Workshop Participants	In-district Sample	Out-of-district Sample	Pennsylvania Comparison Group
Getting help for parents and child (Cont'd)				
-evaluating and following transient families	1	1		
-getting family together again	1			
Percent Responding	11.5%	23.3%	48.4%	
Testifying in court	8	1	1	
-physician's legal responsibilities	3	2		
-especially about sexual abuse cases				1
-especially about emotional abuse cases				1
-physician's protection from suit after reporting	3			
-lack of court recognition of problem	1			
-education for legal profession			3	
-complacent court	1			
-lack of court action on problem	1	1		
-time wasted by court	1	1		
-cooperation with legal people	1	2	1	
-determining need for foster care versus severance of parental rights	1			
Percent responding	17.7%	11.7%	16.1%	50.0%
TOTAL NUMBER OF RESPONDENTS	113	60	31	4

TABLE 16

GAINS ON OBJECTIVE TEST OF KNOWLEDGE

Knowledge Area	Pre-test Mean	Post-test Mean	Number of Respondents	Number of Test Items	Change	t-test	p
Diagnosis	5.70	6.67	72	9	0.97	3.76	0.001*
Case management	1.61	1.61	72	2			1.00
Interviewing	2.96	2.91	72	4	-0.5	-0.41	0.682
Legal aspects	6.16	7.04	72	10	0.89	3.33	0.001*

* $p < 0.01$ on χ^2

The diagnosis and legal areas had more than twice as many test items as the interviewing and case management areas. This would tend to increase reliability of the mean responses, thereby increasing the probability of discovering true effects.

Respondents rated themselves on both knowledge of and confidence in performing various activities. Ratings were on a three-point scale (high = 3, moderate = 2, little = 1). The mean self-ratings and gains are given in Table 17.

Statistically significant gains were made in identification of physical abuse and of sexual abuse on both knowledge and confidence questions. Physicians rated themselves as reasonably knowledgeable and confident in identification of physical abuse (pretest means of 2.41 and 2.37, respectively) but relatively lacking in knowledge of identification of sexual abuse (pretest means of 1.81 and 1.72, respectively). Statistically significant improvement occurred in the self-related knowledge of case management. All other areas showed improvement, but the improvements were not statistically significant.

Participants used a three-point scale to rate their own knowledge of several topic areas in child abuse and neglect. The results are given in Table 18.

TABLE 17

MEAN SELF-RATINGS AND GAINS ON KNOWLEDGE AND CONFIDENCE IN VARIOUS ACTIVITIES

Activity	Pretest Mean	Post-test Mean	Number of Respondents	Mean Change	t-test	p
Identification of physical abuse -						
knowledge	2.41	2.62	82	0.21	3.65	0.001**
confidence	2.37	2.62	68	0.25	3.90	0.001**
Identification of emotional maltreatment -						
knowledge	2.01	2.07	81	0.06	0.93	0.356
confidence	1.94	2.00	67	0.06	0.84	0.375
Identification of sexual abuse -						
knowledge	1.81	2.11	81	0.30	4.04	0.001**
confidence	1.72	1.96	68	0.24	2.80	0.007**
Identification of neglect -						
knowledge	2.40	2.43	81	0.04	0.55	0.581
confidence	2.39	2.46	67	0.07	0.96	0.340
Reporting -						
knowledge	2.58	2.63	81	0.05	0.81	0.418
confidence	2.55	2.65	69	0.10	1.72	0.090
Referral -						
knowledge	2.37	2.47	81	0.10	1.47	0.145
confidence	2.33	2.48	69	0.14	1.80	0.077
Case Management -						
knowledge	1.88	2.05	81	0.17	2.21	0.030*
confidence	1.77	1.91	69	0.14	1.74	0.086

* $p < 0.05$ on χ^2

** $p < 0.01$ on χ^2

TABLE 18

MEAN SELF-RATINGS AND GAINS IN KNOWLEDGE OF VARIOUS TOPICS RELATED TO CHILD ABUSE

Topic Area	Pretest Mean	Post-test Mean	Number of Respondents	Mean Change	t-test	p
Reporting obligations of my state law	2.48	2.75	81	0.27	3.99	0.001**
Legal safeguards protecting me from liability	2.32	2.65	81	0.33	3.96	0.001**
Procedures for interagency referral	2.18	2.39	81	0.21	2.51	0.014*
Procedures to report a case of child abuse	2.63	2.71	79	0.08	1.10	0.276
Legal definitions of physical abuse in my jurisdiction	1.92	2.42	80	0.50	5.51	0.001**

* $p \leq 0.05$ on χ^2

** $p < 0.01$ on χ^2

Statistically significant gains were made in four of the five areas. Respondents were also asked to rate their understanding of the role various organizations or individuals play in regard to child abuse and neglect. The scale had three measures: 3 = good understanding, 2 = moderate understanding, 1 = little understanding. The results are given in Table 19, which shows that statistically significant gains in understanding occurred in most areas.

TABLE 19

MEAN SELF-RATINGS AND GAINS IN UNDERSTANDING VARIOUS ORGANIZATIONS' ROLES

Organization/ Individual	Pretest Mean	Post-test Mean	Number of Respondents	Mean Change	t-test	p
Police department	1.97	2.18	78	0.20	2.55	0.013*
Schools	1.90	2.15	78	0.26	3.37	0.001**
Day-care centers	1.67	1.96	76	0.29	3.47	0.001**
Mental health centers	1.91	2.16	75	0.25	2.98	0.004**
Hospitals	2.48	2.60	77	0.12	1.41	0.161
Public health departments	2.02	2.32	79	0.29	3.43	0.001**
Social service department	2.46	2.64	78	0.18	2.40	0.019*
Private physicians	2.16	2.44	77	0.29	2.28	0.007**

* $p < 0.05$ on χ^2

** $p < 0.01$ on χ^2

Respondents rated on a three-point scale their confidence to perform several activities related to child abuse and neglect. Statistically significant gains from pre- to post-test were apparent. These results are given in Table 20.

TABLE 20

MEAN SELF-RATINGS AND GAINS IN CONFIDENCE TO PERFORM VARIOUS ACTIVITIES

Activity	Pretest Mean	Post-test Mean	Number of Respondents	Mean Change	t-test	p
To counsel an abusive parent to accept help	1.96	2.23	79	0.27	3.99	0.001**
To assess family needs	1.87	2.09	79	0.21	3.23	0.002**
To develop a treatment plan	1.64	1.96	78	0.32	4.46	0.001**
To follow through with other persons or agencies	2.28	2.35	78	0.06	0.90	0.373
To prepare for court and court testimony	1.92	2.28	78	0.36	5.68	0.001**
To provide court testimony	1.95	2.27	78	0.32	4.78	0.001**
To convey information on child abuse to others	2.27	2.45	78	0.18	2.27	0.026*
To discuss a case of child abuse with a colleague	2.51	2.64	78	0.13	1.92	0.058

* $p < 0.05$ on χ^2

** $p < 0.01$ on χ^2

2, r=0.26, N=106, p=0.008; question 6, r=0.26, N-106, p=0.006; question 7, r=0.31, N-106, p-0.001; question 11, r=0.30, N=106, p=0.002; and question 14, r=0.20, N-105, p=0.042). Similarly, the number of suspected instances of child abuse and neglect physicians reported during the past year was also significantly related to several questions in Table 11 (question 6, r=0.28, N=104, p=0.004; question 7, r-0.29, N-104, p=0.003; question 10, r=0.22, N-104, p-0.026; and question 11, r=0.24, N=104, p=0.015).

To assess whether some participants learned more than others, statistically significant gains were correlated with the respondents' background characteristics and with gains on other items. The most valuable findings were that the following variable tended to be negatively correlated with gains in knowledge:

--age;
--number of suspected instances of child abuse/neglect the physician reported during the past year; and
--number of suspected instances of child abuse for which the physician served as an expert witness.

The apparent reason for the foregoing correlations is that individuals high on these variables are also more knowledgeable at the outset and thus have less to learn from the training curriculum. No such argument can be applied to the negative correlation of age with gains in knowledge because age is not correlated with the initial knowledge level of the respondents. Older physicians seem to have as much to learn about child abuse as younger ones, but the training program did not help them as much.

Another trend discovered is that those who felt that obstacles to reporting child abuse in Table 14 were more severe than the average, also tended to rate themselves as gaining more than the average in knowledge (including knowledge in legal areas). However, this same result was <u>not</u> found with gains in the objective test on knowledge in legal concerns; there was essentially no relationship between the judged severity of obstacles to reporting and gains in legal knowledge as objectively measured.

Gains on one knowledge item also tended to be positively correlated with gains in knowledge on other items, but only for items from within the objective and self-rated portions of the questionnaires, i.e., gains in knowledge as measured objectively were <u>not</u> related to gains in knowledge as self-rated. Thus, there was at least some evidence that, if individuals gained knowledge from the training program, they tended to gain in all content areas.

Items from Tables 17-21 can be grouped into a few categories to review the gains made in each area. Substantial gains were made on all questions concerning legal aspects of child abuse (questions 4, 13, 16, 29, 30) and almost all questions concerning the role played by local agencies in child abuse (questions 17, 18, 19, 20, 21, 22, 23, 24). Questions pertaining to case management (questions 2, 11, 25, 26, 27) and questions concerning diagnosis (questions 1, 5, 6, 7, 8) showed significant change. However, gains were noticeably absent in subareas of identification of emotional maltreatment and neglect because the Unit 14 curriculum materials did not specifically discuss these areas. The categories of interviewing (question 3), reporting (questions 9, 12, 15) referral (questions 10, 14, 28), and liaison (questions 31, 32) showed some change, although it was inconsistent.

Comparison of the pre- and post-test narrative questions on legal issues (questions 110-114) showed that most participants came to the workshop knowing a brief, accurate, legal definition of the terms "child abuse" and "neglect". In the post-test the definitions were expanded but not substantially different. Most participants also knew it was mandatory for physicians to report abuse, but on the post-test many indicated that they had learned suspected incidents must also be reported. Most respondents knew they were protected by law from suit. Also, the majority of participants knew what information to report and to whom reports should be made before the course. Although most physicians who completed these items knew where to begin the reporting process, there was a certain amount of vagueness and uncertainty about interagency referrals. The reporting process did not appear to have been clarified by the course.

Correlations among responses of the three samples to questions on background, attitudes, and knowledge were not generally large in absolute value (i.e., between 0.2 and 0.4). However, a number of significant correlations emerged when questions from the various content sections were related within the workshop sample alone. Changes in self-ratings on the level of knowledge were positively related to (1) the number of suspected incidents of child abuse and neglect a physician was substantially involved with, the number in which a physician had filed a report, and the number in which a physician had testified as an expert witness during the previous year; and (2) prior training in child abuse and neglect. The physician's age was positively related ($r=0.28$, $N=104$, $p=1.004$) to disagreement with the statement that "health professionals are reluctant to admit to themselves that anyone, particularly a regular patient, could abuse a child" (Table 11, question 6). The number of suspected instances of child abuse the physician was substantially involved with during the last year was also significantly related to other questions in Table 11 (question

Change in Attitude

Respondents were asked in the post-test if they felt their attitudes toward working with parents suspected of abusing or neglecting their children had changed as a result of the program. The 76 respondents represented 60.3% of the 126 participants; of these, 46% answered "yes." The following attitude changes were mentioned, in decreasing order of frequency:

--feel less punitive, more helpful and sympathetic toward parents: 19/33 (57.6%)

--have increased confidence in dealing with such knowledge: 8/33 (24.2%)

--feel more confident in interviewing the parent: 3/33 (9.1%)

--feel more confident in my reporting responsibilities: 3/33 (9.1%)

--used to feel these parents were hopeless, now I see the possibility of helping both the parent and child: 2/33 (6.1%)

Most of those who reported no change in attitude as a result of the course felt that their attitudes were already those described; many of them had considerable experience in this area. Examination of the changes in responses to the objective attitude and opinion measures does not confirm the self-reported changes.

Of the 15 questions in Table 11, only one showed a statistically significant change from pretest to post-test (question 13, t=2.75, N-83, p=0.007). But none of the items, including this one, showed any large mean changes in the workshop sample.

More of the items in Tables 12, 13, and 14 than in Table 11 showed statistically significant changes from pretest to post-test in the workshop sample (questions in Table 12——8, 12, 14, 18, 22; Table 13——2, 3, 9, 10, 11, 13; Table 14——5, 15). These changes were also minor because the correlation between the mean responses to these items on the pretest and post-test is the workshop sample are 0.98, 0.93, and 0.94 for Tables 12, 13, and 14, respectively. Thus, although minor changes in individual items may have occurred, the relative orderings of the items within each table did not shift substantially.

Change in Behavior

The pre- and post-questionnaires did not contain any direct measures of behavior, but the post-test asked respondents whether their practice or behavior would change as a result of attending the workshop. A majority (61.8%) of participants said "yes." This is a considerably larger proportion than thought their attitudes were changed as a result of the training program. The narrative responses showed that many participants felt their attitudes prior to the workshop were already appropriate, but many of them learned one or more skills at the session which would change their practice. Participants reported they expected the following behavioral outcomes, in decreasing order of frequency:

--increased knowledge and confidence will be reflected in behavior 27.7%

--greater alertness/sensitivity to existence of abuse and neglect while performing routine examinations 14.9%

--will conduct interview more effectively 12.8%

--will be more likely to report suspected abuse/neglect 10.6%

--will behave more sympathetically toward parents 10.6%

--will be less punitive toward parents 8.5%

--will display more confidence as witness in court 8.5%

--will do better job of diagnosing abuse and neglect 6.4%

--will talk with colleagues about abuse and neglect 4.3%

--will approach the parents using knowledge of the behavioral (observation) techniques 4.3%

--will be a more effective teacher of residents 2.1%

--will develop prevention program at our hospital 2.1%

Nearly all who reported that their behavior would not change said they had already been doing the prescribed activities.

In the follow-up telephone survey conducted 2 to 4 months after the sessions (refer to Appendix 1), 54.1% of the workshop participants reported that, since the course, they had seen children they suspected were abused or neglected. They were asked, "What, if anything, did you do differently than before the workshop?" A number of changes were cited (See Table 21). These changes include being more aware of the existence of the problem during routine patient exams (10%): behaving more sympathetically toward the parents rather than showing anger, as in the past (15%); documenting the history more carefully than previously (10%); reporting more aggressively (10%); and being much more confident in court (10%). Of those contacted, 45.9% had not seen any suspected abuse since the workshop. Of these, 58.8% would do nothing differently in handling child abuse in the future. Most of this group were older, more experienced administrators and medical school faculty who felt that they had been doing the described activities for some time. Of the physicians who said they had not seen suspected abuse since the workshop. 35.3% indicated they would do things differently. They were asked "Did you discuss ideas from the workshop with your colleagues?" Ninety-five percent of the participants said yes. Colleagues included partners (5.4%), emergency room personnel (5.3%), medical students and residents (13.2%), ambulance drivers (2.6%), nurses (5.3%), and physicians in the health department (5.3%).

Aspects of the workshop were discussed by 43.8% with representatives of social service agencies; 35.3% with attorneys; 63.6% with others (including Junior League mental health personnel, teachers, school nurses, church groups, Parents Annonymous, friends, and family members). Learning from the workshop was applied by 20% in working with parents. Other outcomes included one participant who developed a protocol for handling suspected abuse in the hospital emergency room, another who made a special effort to learn about referral sources in the community, and a third who wrote child abuse and neglect into the Academy chapter state health plan.

TABLE 21

SUMMARY OF RESPONSES TO FOLLOW-UP TELEPHONE INTERVIEW

		Yes	No
I.	Suspected abuse or neglect seen since the workshop	54.1%	45.9%

yes 54.1%

What, if anything, did you do differently?

--more suspicious 11.1%
--conduct parent interviews more effectively 5.6%
--more sympathetic toward parents, rather than angry as previously 16.7%
--more careful in documenting history 11.1%
--called police to take photos of the child 5.6%
--handled sexual abuse better 5.6%
--report more aggressively 11.1%
--more prone to notify social services and juvenile department 5.6%
--made proper referral 5.6%
--notified others (had handled abuse or neglect alone) 5.6%
--now act with understanding of state reporting law (did not understand prior to workshop) 5.6%
--more grave in court 11.1%

no 45.9%

What, if anything, would you do differently if you saw an abused or neglected child?

--more attuned to physical findings, more suspicious 60%
--less hesitant to report suspected instances 40%

		Yes	No
II.	Did you discuss ideas from the workshop?		
	A. -with colleagues?	94.7%	5.3%

Yes 94.7%

--partner(s) 5.3%
--peers in outpatient department 2.6%
--on child protection team 2.6%
--emergency room personnel 5.3%

TABLE 21 (CONTINUED)

A. - with colleagues? (continued)

yes 94.7%

--medical students or residents 13.2%
--health department personnel 5.3%
--lecture to hospital nurses 5.3%
--lecture to ambulance drivers 2.6%
--lecture at medical school 2.6%
--at Academy chapter level and committee chapter level 2.6%

no 5.3%

	Yes	No
B. -with social services	43.8%	56.3%

	Yes	No
C. -with legal representatives?	35.5%	64.7%

yes 35.5%

--with state's attorney 8.3%
--informally 41.7%
--wrote letter to district attorney 8.3%
--now bring own attorney to hearings to advise 8.3%

no 64.7%

	Yes	No
D. -with patients?	20.0%	80.0%

yes 20.0%

--informally 16.7%
--because they have asked about it 16.7%
--discussed anger toward their child as normal 16.7%
--counseled an abusive parent 16.7%
--used some material from legal module to explain to parents why it is necessary to report them 16.7%

no 80.0%

TABLE 21 (CONTINUED)

	Yes	No
E. -with others?	63.6%	36.4%

yes 63.6%

--with people in the community 14.3%
  --Junior League 14.3%
  --mental health personnel 14.3%
  --teachers 9.5%
  --school nurse (promised to back her up in reporting) 4.8%
  --church group 4.8%
  --Parents Anonymous 4.8%
--with friends 19.0%
--with family 9.5%

no 36.4%

III. Other behavioral outcomes?

--as a result of the workshop made a concerted effort to learn about referral sources available locally
--developed protocol at hospital emergency room
--wrote child abuse and neglect into Academy chapter state health plan

IV. Participant comments on value of NCCAN curriculum materials

--extremely informative 27.3%
  --especially slide/tape on diagnosis 16.7%
  --especially materials on interview 8.3%
  --especially legal materials 41.7%
--satisfactory, good course 22.7%
--needs to be revised, condensed 4.5%
--too elementary, but a good introduction 34.1%
  --especially valuable for senior medical students, residents, and young physicians 20%
--needs a more in-depth follow-up course 2.3%
--poor audio-visual aids, except for diagnosis slide/tape and medical witness film 2.3%
--should deal with treatment 2.3%
--should discuss role of clergy in reporting and treatment 2.3%
--good training format (Task Force composition) 2.3%

It is difficult to ascertain which behavioral outcomes are a result of the NCCAN curriculum materials, which are a result of the supplementary materials, and which are more a result of the unique skills and personalities of the Task Force trainers. The rather critical participant comments on the training package seems to indicate that much of the positive behavioral outcome was a result of the excellent leaders at each session, who elaborated on the curriculum and supplementary material. Apart from the two medical-legal modules, much of the most helpful and best received material was supplemental, such as the slide/tape on diagnosis, the videotaped interviews from the University of Colorado, and evaluation plans based on the trainer's experiences.

SECTION V

CONCLUSION

Overall Comments on the Curriculum and Workshop Sessions

Participants were asked for their evaluation of the training program on two occasions, during the post-test and at the follow-up telephone interview. In an effort to combine evaluation of the NCCAN material with the presentation of high quality continuing medical education course, supplementary materials were used (Appendices D and O). Those in attendance were not told which materials were developed by NCCAN and which were supplementary.

In the last section of the post-test, participants were asked for a critique of the curriculum and the training program. Respondents were asked to rate various aspects of the curriculum as "very useful," "of some use," and "not useful." The percentage of those responding in each of these categories and the mean response for each question are given in Table 22. In response to the question whether the training program was useful, the majority (65.6%) answered "very useful," and less than 2% answered "not useful." The responses were only slightly less positive on the question whether the training program met specific needs of the respondents. A majority (55.7%) answered "very useful;" only 3.4% answered "not useful." The sections of the curriculum on identification of physical abuse and reporting received excellent ratings, with 79.5% and 55.7% describing them as "very useful." All other sections of the curriculum (see Table 22) could be classified in the "of some use" category, and only the section on identification of emotional maltreatment received a substantial proportion of "not useful" ratings (23.5%).

In response to the question about how the training was put together, most participants (86.4%) answered either "excellent" or "good". The majority of respondents (68.5%) also considered the level of training as "about right", although 11.5% felt it was judged by 68.5% to be "about right", by 19.1% as "too long", and by 12.4% as "too short."

Far more respondents classified the training facilities as conductive to getting the material across than did not (89.8% versus 10.2%). In response to questions on the amount of informal contact with trainers and other trainees, the majority answered "about right" (77.4% and 75.9% respectively); most other respondents answered "not enough" (22.6% and 22.9% respectively).

TABLE 22

EVALUATION OF CURRICULUM AND TRAINING PROGRAM
(Percent Responding)

Question	Very useful	Of some use	Not useful	Mean Response
The training was...	65.6	33.3	1.1	2.64
Did training meet specific needs?	55.7	40.9	3.4	2.52
Training material on:				
-identification of physical abuse	79.5	19.3	1.1	2.88
-identification of emotional maltreatment	22.4	54.1	23.5	1.99
-identification of neglect	31.8	54.5	13.6	2.18
-identification of sexual abuse	38.6	52.3	9.1	2.29
-reporting	55.7	37.5	6.8	2.49
-referral	43.7	43.7	12.6	2.31
-case management	27.6	59.8	12.6	2.15

The remaining questions concerning presentation of the workshop asked respondents to express their opinions on a five-point scale. These questions and the responses are given in Table 23. In summary, respondents felt that (1) the material was easy to understand, (2) the material was relevant to child abuse issues, (3) the trainers were competent, (4) the trainers understood the problems relating to child abuse, (5) the trainers were interested in helping the participants learn the materials, and (6) the trainers dealt adequately with requests for assistance and issues under discussion.

TABLE 23

RESPONDENT COMMENTS ON TRAINING MATERIALS AND TRAINERS
(IN PERCENT)

Question	1*	2	3	4	5
Training Materials					
Difficult to understand	1.2	3.5	12.8	29.1	53.5
Relevant to child abuse	56.3	20.7	11.5	5.7	5.7
Trainers					
Trainers were competent	67.4	24.4	4.7	2.3	1.2
Trainers understood problems related to child abuse	66.3	27.9	1.2	3.5	1.2
Trainers were interested in seeing participants learn material	54.0	31.0	9.2	4.6	1.1
Trainers dealt adequately with requests for assistance and with issues under discussion	49.4	27.6	14.9	3.4	4.6

*Responses were on a continuum where 1 - strongly agree and 5 - strongly disagree.

The majority of respondents would both recommend this training program to colleagues (84%) and advise that colleagues pay for the training if the cost were about the same as other training programs (80%). Opinions of the participants on how useful this training program would be for various professionals are presented in Table 24.

Younger physicians contacted in the telephone interview seemed to find the program especially informative. They cited the slide/tape on diagnosis, the materials on interviewing, and the legal modules as most helpful. More experienced pediatricians found the workshop a satisfactory introductory course, although the material presented was below their experience level.

They recommended including the workshop material in medical school and residency training. They also felt that a more in-depth sequel course should be developed.

TABLE 24

PARTICIPANTS' OPINION OF THE USEFULNESS OF THE TRAINING MATERIAL

Profession	very useful (%)	of some use (%)	not useful (%)	can't say (%)
Physicians in Practice	76.5	23.5	0	0
Physicians in Training	80.5	19.5	0	0
PNP's/PNA's	70.2	27.4	0	2.4
RN's	62.8	34.9	0	2.3
Occupational therapists	31.8	29.4	20.0	18.8
Physical therapists	31.8	28.2	21.2	18.9

A number of proposed curriculum revisions were also mentioned in the follow-up interview. Section IV discusses these in detail and mentions issues omitted from the preliminary version of the curriculum. Two areas which were not mentioned in Section IV because they do not fit neatly into any of the existing modules are stress on professionals as a result of their work with abusive and neglectful families and the role of the clergy. The stress on professionals is tremendous because working with troubled families is traumatic. Professionals should not be involved full-time in child abuse, and they should not be working alone. It is advisable to work in groups to compare perceptions of a situation, share feelings, and help make decisions. Chaplains, priests, and pastors appear to have been totally overlooked in the NCCAN curriculum. They are in a unique position to counsel abusive and neglectful families, yet they have almost no training in recognizing or following up on suspected abuse and neglect.

The following broad topics should be developed into separate modules as they apply to health professionals:

Prevention, including

--maternal/infant bonding,

--identification of families in which abuse or neglect is likely to occur,

--relationship of alcohol and drug dependency to child abuse and neglect,

--public awareness programs.

Guidelines for selecting appropriate treatment modalities to work with the family.

Suggested Curriculum Revision for Minority Populations

Steering Committee and Task Force members and a substantial number (35.3%) of the workshop respondents agreed that NCCAN Unit 14 needs revision to make it more effective for use with trainees of racial or ethnic minority groups and for those who work with these populations. Materials need to be included on how the definitions of abuse and neglect apply to different cultures. For example, to work successfully with Native Americans, cross-cultural techniques need to be developed which take into consideration the tribal clan systems. This is especially important because Anglo-American physicians are the health care providers to the majority of Native Americans. Cultural differences indicate that it is necessary to modify the approach used in the parent interview.

Other issues for consideration include the incidence of and attitude toward father-daughter incest in some Appalachian communities, the practice of cao gio or "scratch the wind," among certain Vietnamese, such unusual dietary beliefs as "hot" and "cold" foods which might explain deliberate withholding of certain foods, and the belief of some persons of Asian descent that it is necessary to withhold all food and liquids from a child having diarrhea. All social and ethnic groups need to be represented in the audio-visual materials. Several participants suggested that the revised curriculum, or selected portions of it, should be translated into the various Spanish dialects and made available to Mexican and Puerto Rican communities. Table 25 presents responses to opinions about the usefulness of the training materials for meeting the needs of various racial, ethnic, and cultural groups.

TABLE 25

USEFULNESS OF THE TRAINING MATERIALS
FOR VARIOUS POPULATIONS

Racial/Ethnic/ Cultural Group	very useful (%)	of some use (%)	not useful (%)	can't say (%)
White	40.7	30.2	3.5	25.6
Black	32.1	31.0	4.8	32.1
Native American	19.0	36.9	9.5	34.5
Hispanic American	19.0	31.0	9.5	40.5
Asian American	17.9	28.6	11.9	41.7

Recommendations for Improving Quality of Treatment Services

Respondents were also asked how they thought the quality of medical treatment services for abusive and neglectful parents could best be improved. Each suggested method was rated on a four-point scale (1 = very much needed, 2 = helpful but not critical, 3 = sometimes helpful, and 4 = not helpful). Table 26 gives the list of suggested improvements.

Reservations or Cautions About Use of the Curriculum

Some cautions about use of the training materials have been discussed in Section IV. The following general remarks may be added to the specific considerations mentioned in that section.

There is no clear distinction made between emotional abuse and emotional neglect. Trainers must stress that much of the data amassed on characteristics of abused and neglected children and their parents is retrospective and incomplete.

Throughout the modules reviewed by the Academy, there was no clear statement that a physician alone cannot make the diagnosis of child abuse and neglect. Physicians need social data, information from the physical examination, medical and developmental histories, and laboratory data. However, the physician must have a high index of suspicion, and the training sessions should be designed to promote this.

TABLE 26

SUGGESTIONS FOR IMPROVING QUALITY OF MEDICAL TREATMENT FOR FAMILIES

Suggestion	Mean Response
More and better public education about problems of child abuse	1.13
Develop and disseminate standards for diagnosis and treatment	1.31
Increase understanding from colleagues for those who treat child abuse	1.33
A physician hotline with a consultant available for discussing specific cases	1.71
Internship rotations in child abuse treatment	1.75
More treatment units for referral	1.81
Credits toward certification of continuing medical education	1.82
Consultants to come to office or hospital for assistance in treatment	1.99
Residency programs in child abuse	2.11

Trainers need to point out that the development of a treatment plan and community provision of services are not addressed.

Individuals who rated the training program most highly also tended to gain the most on self-rated knowledge items. This correlation between gains and evaluation items would tend to validate the responses to the evaluation questions. Positive comments on the training program as a whole tended to come from those who had received prior training rather than from those who had received no previous training. These results suggest that the Academy workshops were extremely useful, especially when compared to other training the respondents had received.

Based on responses in this curriculum evaluation project, some portions (especially Modules I, VI, and VII of the program) are effective training materials, but NCCAN Unit 14 as a whole contains considerable material which is poorly conceived and poorly presented. The weaker parts of it need to be improved by substantive and technical revision and important subject areas omitted from the field test version need to be included.

Comments on Use of Curriculum Materials for Training Physicians

Respondents were asked what methods would be most helpful for continuing education of physicians in problems of child abuse and neglect. Each suggested method was rated on a four-point scale (1 = very helpful, 2 = generally useful, 3 = sometimes useful, and 4 = not helpful). Table 27 presents the list of suggested methods in order of their related usefulness.

TABLE 27

METHODS FOR IMPROVING CONTINUING EDUCATION

Method	Mean Response
Continuing education courses through universities or medical societies	1.53
Lectures by authorities at medical meetings	1.58
Panel discussions by authorities at major conferences	1.60
Films shown at hospital staff meetings	1.68
Monographs on child abuse topics sent to all practicing physicians	1.77
Videotape cassettes for viewing in hospital staff rooms	1.82
Articles in specialty journals	1.98
Digest of important articles sent to every physician	2.00
Audio cassettes which physicians could purchase for self-study	2.04

Contrary to the impression given by the small physician attendance at most interdisciplinary workshops on child abuse and neglect, many pediatricians appear interested in receiving training on the subject. The following recommendations for improving physician training in child abuse and neglect arose out of the workshops conducted.

Many participants felt that the materials should be used in small, statewide workshops similar to those conducted under this grant (at least for primary care physicians, pediatricians, family practice physicians, and emergency room physicians). Workshops should be statewide (regional meetings should break into groups according to state) to consider variations in state reporting statutes and protocol for handling suspected abuse. Respondents indicated that a series of hospital-based seminars sponsored by a professional medical association of local/state medical society would be the most effective approach for attracting physicians. The training should be in shorter segments than the full-day workshop presented, perhaps two half day seminars offered as one of several concurrent sessions at meetings which are part of their ongoing, accredited, continuing medical education program. Perhaps short segments could be self-administered, e.g., as a cassette tape package and manual. Hospitals might use portions of it as grand rounds. Many respondents to this item felt that the material should be covered during medical school, and that chairmen of medical school departments of pediatrics, family medicine, and emergency medicine should be notified of the availability of the final curriculum. Sessions should be publicized 3 to 4 months in advance so patient appointments will not be scheduled for those dates.

Participants said it would have been helpful to have received all the resource materials 2 to 3 weeks before the session. The materials were not sent at that time because information learned from reading them would have affected the pretest results. Also, it was feared that many would not remember to bring the materials to the workshops. However, mailing these materials in the prepackets should be considered for future sessions. In their postpackets participants should receive a set of correct responses to the test items, with a rationale for why the chosen answer was preferred over others.

Several participants complained about the length of the questionnaires. The forms required a long time to complete because of the detailed nature of the data collected, and this interfered with their return. The forms need to be condensed before future sessions. A few respondents felt that the sessions should have allowed more time to relate to other trainees. One pediatrician wanted to hear about trainer personal experiences testifying in court.

Comments on the composition of workshop faculty were extremely favorable. Trainers for each session consisted of one Fellow from the state chapter, one "outside expert" Fellow, and an attorney experienced in child abuse and neglect from the state where the session was held. A local child protective services worker also participated in most of the sessions. A suggestion was made to include representatives of the police and the school system on open-panel discussions. An effective technique at one session was a panel discussion after each module was completed. These discussions involved local persons (e.g., a hospital radiologist and orthopedist) who spoke about how diagnosis relates to their experience. A behavioral objective for the workshop could be for participants to develop a detailed protocol for handling suspected abuse in the communities represented if none currently exists.

The sequence of model agenda items met with little criticism, except that one participant recommended discussing the definitions of child abuse and neglect at the beginning of the program. It would also seem a good idea to present data on local incidence before proceeding with Module I. Developing an evaluation plan was most effective in the early afternoon because participants became actively involved in discussion. The legal modules were scheduled last, which helped hold interest throughout the day.

To heighten public awareness of the problem of child abuse and neglect, media representatives should be invited to cover each workshop.

Comments on Physical Facilities

Participants made several comments on the qualities an appropriate workshop facility should have. Most of these remarks were made because participants were pleased with the way these items were handled at their sessions. Workshops held at hospitals or medical schools would be most attractive to physicians because they are readily accessible and charges for room and equipment rental and for food service are minimal. Arrangements for these services can usually be made by telephone with the hospital department of medical education. A private conference room furnished with upholstered seating and tables is desirable. The ceiling should be low enough to minimize acoustical problems, especially when cassette-tapes are used. However, a professional cassette tape player should be arranged for in case acoustics are poor. A high, built-in screen will allow good visibility and is preferable to a standing screen. Videotapes are difficult to see in groups of 15 or larger because of the size of the monitor screen.

Ideally, trainers should carry their own equipment with them; in reality this is often impossible, especially with the variety of media used to present the NCCAN materials. Support staff should arrive on the site early the day before the

workshop is scheduled to confirm arrangements and become familiar with rented equipment by doing a complete test run. The curriculum recommendation that there be no more than 20 participants per trainer is considered a good idea because an informal seminar lends itself to more free discussion than a large group session. Generally, participants appreciated the "no smoking" regulation. A complimentary light and attractive buffet luncheon was catered at each session to enable good use of the limited time available.

SECTION VI

SUMMARY

During a 1 year grant from NCCAN, the Academy evaluated the child abuse and neglect curriculum materials developed by NCCAN for training physicians and other health professionals. The evaluation was conducted through a series of eight workshops based on the materials and held in one Academy district in the Upper Midwest (District VI). A ninth program was presented as a seminar at the Academy's Spring Session. Workshop leaders were Fellows who had received previous training in the curriculum materials. Two pediatricians led each session, one from the state where the workshop was held and the other from outside District VI. Local legal and child protective service persons also gave presentations at the sessions. Continuing medical education credit was given for attendance.

The 1-day program was attended by 126 physicians, nearly all members of the Academy. Participants were asked to complete a three-part battery of questionnaires which gathered pre- and postworkshop data on their knowledge of, experience in, and attitudes toward working with families suspected of abusing or neglecting their children. The questionnaire also collected demographic data, a critique of each curriculum module, and comments on the training program as a whole. A sample of participants was contacted by telephone 2 to 4 months after the session to provide information on behavioral outcome resulting from course attendance.

Two control groups were identified, one of Fellows in District VI who did not attend the program and one from a nationwide pool of Fellows. These populations were compared with workshop participants on the items discussed to determine whether those who attended were representative of Academy membership in and out of District VI. Analysis of the returned questionnaires indicated that participants constituted a reasonable representative sample of Fellows inside and outside their district.

In general, respondents found the modules on diagnosis and legal issues to be the most helpful parts of the curriculum. The self-reported gains in these knowledge areas were also reflected in post-test gains on objective items. Gains in knowledge appeared to correlate negatively with (1) age, (2) the number of suspected instances of child abuse and neglect a physician was substantially involved with, (3) the number of incidences the physician had filed a report on, (4) the number of incidences the physician had testified in court about during the previous year, and (5) prior training in child abuse and neglect. About half the participants reported the workshop had

in some way changed their attitude toward working with suspected abuse. Most reported changes were that respondents felt less punitive toward the parents and an increased confidence in their ability to handle suspected abuse and neglect as a result of newly acquired knowledge. Most of those who reported no change described their attitude prior to the workshop as desirable.

A majority of respondents reported in the postquestionnaire that their behavior would change as a result of the course. In the subsequent telephone interview, more than half of those contacted reported seeing suspected abuse since the workshop. Behavioral outcomes attributed to the training program included a higher index of suspicion, more effective interviewing techniques, more careful documentation of the history, more aggressive reporting, more sympathetic treatment of parents, and a discussion of curriculum content with colleagues and community representatives.

Two important content areas omitted from the NCCAN curriculum were prevention and treatment. It was strongly recommended that these items be developed into separate modules. Other areas recommended for more extensive development were the diagnosis of neglect and emotional maltreatment and the application of the definitions of abuse and neglect to racial, ethnic, and cultural groups.

Evaluation of the NCCAN curriculum materials is difficult to separate from the influence of the supplementary material selected and the unique expertise shared by the trainers. Much of the most highly rated training material was supplementary.

On the basis of (1) review by the Steering Committee and Task Force, (2) narrative participant critiques of the materials, and (3) gains indicated by comparison of pre- and post-test scores, the condensed and supplemented version of NCCAN Unit 14 is an acceptable introductory course on child abuse and neglect for physicians, especially for senior medical students and residents. However, to be more effective as an educational program, much of the original Unit 14 material needs major substantive and technical revision, and several important subject areas omitted from the preliminary version of the curriculum need to be developed into separate modules.

Workshop participants believe that implementing the suggested recommendations will attract more physicians to a continuing medical education course using the kind and quality of curriculum materials described in this report. The revised curriculum needs to address treatment issues and focus especially on the role of health professionals in prevention of one of the nation's most crucial social problems.

APPENDIX A

ROSTER OF CA/N STEERING COMMITTEE MEMBERS

John E. \llen, M.D., FAAP, Chairman
Former Chairman, Subcommittee on Child Abuse and Neglect, Committee on Infant and Preschool Child
Bayville, New Jersey

R. Don Blim, M.D., FAAP
Chairman, District VI and member of the Executive Board
Kansas City, Missouri

Rowland L. Mindlin, M.D., FAAP
Chairman, Committee on Infant and Preschool Child
Brooklyn, New York

Academy Staff Members

Gerald E. Hughes, M.D., FAAP
CA/N Project Director and Assistant Director, Department of Educational Affairs

Jean D. Lockhart, M.D., FAAP
Director, Department of Committees

Alexander Hatoff, M.D., FAAP
Director, Department of Chapters and Membership

Ms. Laurene S. Hughes
CA/N Project Administrator

Mrs. Glennis G. Lundberg
Assistant to CA/N Administrator

Mrs. Mary L. Richardson
District VI Field Service Representative

Mrs. Mary G. Tenne
Administrative Assistant, Department of Committees

Ex-Officio Staff Member

Richard W. Olmsted, M.D., FAAP
Director, Department of Educational Affairs

PRESIDENT
MERRITT B. LOW, M.D.
86 HIGH STREET
GREENFIELD, MASS. 01301
VICE PRESIDENT
DAVID W. VAN GELDER, M.D.
888 TARA BOULEVARD
BATON ROUGE, LOUISIANA 70806
EXECUTIVE DIRECTOR
ROBERT G. FRAZIER, M.D.
ASSOCIATE DIRECTOR
RICHARD W. OLMSTED, M.D.
SECRETARY
GERALD E. HUGHES, M.D.
TREASURER
GEORGE A. NAUMAN

American Academy of Pediatrics

P.O. BOX 1034 • EVANSTON, ILLINOIS 60204
EVANSTON (312) 869-4255 CHICAGO (312) 273-3646

DISTRICT CHAIRMEN
SPRAGUE W. HAZARD, M.D.
DEERFIELD, MASSACHUSETTS
MILTON GORDON, M.D.
HUNTINGTON, NEW YORK
WILLIAM A. HOWARD, M.D.
WASHINGTON, D.C.
EDWIN L. KENDIG, JR., M.D.
RICHMOND, VIRGINIA
BRUCE D. GRAHAM, M.D.
COLUMBUS, OHIO
H. DON HEIM, M.D.
KANSAS CITY, MISSOURI
BLAIR E. BATSON, M.D.
JACKSON, MISSISSIPPI
JAMES E. STRAIN, M.D.
DENVER, COLORADO
SAUL J. ROBINSON, M.D.
SAN FRANCISCO, CALIFORNIA
GUILLERMO GUILLEN-ALVAREZ, M.D.
SAN SALVADOR, EL SALVADOR
HELIO SEBASTIAO DE MARTINO, M.D.
RIO DE JANEIRO, BRASIL
JOSE MARIA ALBORNOZ, M.D.
BUENOS AIRES, ARGENTINA

September 3, 1976

The purpose of this letter is to invite you to participate as a trainer of fellow physicians through a demonstration professional continuing education project in the area of child abuse and neglect. You may already be aware that the American Academy of Pediatrics has received a one-year grant from the National Center on Child Abuse and Neglect to evaluate a curriculum developed through a contract with Urban and Rural Systems Associates of San Francisco. (Several of you have, in fact, served in an advisory capacity to URSA in relationship to this project.)

According to the Request for Proposal, the grant is intended

A. "to demonstrate and evaluate the effectiveness of the curriculum on identification, reporting, referral and case management, developed by the National Center on Child Abuse and Neglect, for training professionals working in the fields of medicine and health, education, social work, law, and law enforcement. Effectiveness will be examined with respect to the extent the curriculum

(1) provides additional information and knowledge to the learner,

(2) expands and improves the learner's attitudes toward and sensitivity to the problems of child abuse and neglect, and

(3) improves skills needed by the learner in order to provide services to abusing and/or neglecting families, and

B. to evaluate a variety of methods employed by professional associations to disseminate and utilize the curriculum, in order to determine the types of training needs which may be addressed through the auspices of professional associations and the most effective and efficient approaches for meeting these needs."

An executive committee for this grant has been formed consisting of the following members:

John E. Allen, M.D., Chairman, task force of Child Abuse and Neglect (CA/N) grant

Gerald E. Hughes, M.D., Director, AAP Department of Educational Affairs and Project Director of CA/N grant

Rowland L. Mindlin, M.D., Chairman, AAP Committee on the Infant and Preschool Child (with subcommittee on CA/N)

R. Don Blim, M.D., Chairman, AAP District VI and member of AAP Executive Board

Alexander Hatoff, M.D., Director, AAP Department of Chapters and Membership

Jean D. Lockhart, M.D., Director, AAP Department of Committees

Ms. Laurie Hughes, Administrative Director of CA/N grant

Mrs. Mary Lou O'Donnell, Field Service Representative for District VI

Mrs. Mary Tenne, Administrative Assistant, AAP Committee on the Infant and Preschool Child

The responsibilities of this group were determined to be as follows:

(1) Reviewing the curriculum

(2) Selecting units/elements to be used in the training workshops

(3) Selecting materials to supplement NCCAN curriculum

(4) Identifying possible task force members

On August 20, 1976, this group convened in Chicago for a planning session. At that time the decision was confirmed to develop a series of one-day workshops within District VI of the Academy. These reasons were cited for selecting the District VI model, which had been presented as an alternative in the initial AAP proposal:

(1) Purely fiscal considerations indicate the advisability of saturating one AAP district (preferably the Midwest) rather than scattering the training activities nationwide.

(2) Dr. Blim is highly interested in involving District VI in this activity.

(3) Dr. Hatoff cited a strong level of support for such a training program among the chapter chairmen of District VI.

(4) Mrs. O'Donnell is already in place as a District VI Field Service Representative, through a pilot program funded by the AAP Executive

Board, the District VI membership and other sources raised by Dr. Blim. Through the chapter meetings she would be available to generate interest in the workshops and to provide follow-up support to chapter members.

At that time, the executive committee decided to convene a task force of individuals to serve as trainers for the workshops. The task force would be composed of one pediatrician representing each AAP District other than District VI and one pediatrician from each AAP state chapter within District VI. Task force members would constitute

(1) an advisory body to the executive committee regarding implementation of the action steps of the grant,

(2) a knowledgeable cadre of trainers for the workshops to be held in District VI in conjunction with the grant,

(3) a group of trained resource persons/child advocates to their local communities.

District and chapter chairmen were then approached for names of potential task force members.

There will be a joint meeting of the executive committee and the task force in Evanston on December 3-5, 1976 to receive training in the NCCAN curriculum, which we will have received in final form by October 1. From January through May of 1977 a series of nine one-day workshops will be offered to pediatricians and other physicians at selected hospitals and medical schools throughout District VI. The content of these workshops will be drawn from the NCCAN curriculum and supplemented with other materials. Those in attendance will receive continuing education credit (Category I for the Physician Recognition Award of the American Medical Association). There will also be two one-day joint meetings of the executive committee and task force. The first of these will be held in late February to evaluate the first two workshops and plan for the remaining seven. The second will be scheduled for June to evaluate the activities throughout the grant period as a whole.

Grant funds are available to reimburse task force and executive committee members for travel and expenditures incurred to attend the joint meetings (December 3-5, late February, and June). Honoraria of $100/day will be provided in addition to reimbursement of travel and expense costs for the task force members who serve as trainers in the one-day workshops throughout District VI. It is anticipated that no task force member will be requested to be a trainer in more than two of those workshops.

The AAP proposal states that, in addition to the one-day workshops, selected elements of the curriculum will be reviewed for possible incorporation into the program and exhibits of the fall and spring meetings and into continuing education courses offered through the Department of Educational Affairs. There will be an exhibit publicizing activities under the grant and a number of audio-visuals on child abuse and neglect available for review at the Chicago meeting this October. It has been suggested that for the Spring Session a symposium or round table based upon the curriculum be led by several trained members of the task force. Other possible ways of utilizing the curriculum include incorporating portions of it into PACE (Personal Assessment for Continuing Education).

We hope that the description of activities under this grant has aroused your interest and enthusiasm. Within several days we will be in telephone contact with you to inquire about your availability and interest in participating as a member of the task force.

Sincerely,

John E. Allen, M.D.
Chairman, AAP Task Force

Laurie Hughes

Ms. Laurie Hughes
Administrative Director,
Child Abuse and Neglect Grant

JEA/LH sr

APPENDIX C

TASK FORCE MEMBERS
ABUSED AND NEGLECTED CHILD ABUSE

DISTRICT I

Eli H. Newberger, M.D., FAAP
Children's Hospital Medical Center
300 Longwood Avenue
Boston, Massachusetts 02115

DISTRICT II

Doris L. Wethers, M.D., FAAP
St. Lukes Hospital Center
Amsterdam Avenue at 114th Street
New York, New York 10025

DISTRICT III

Glen S. Bartlett, M.D., FAAP
Department of Pediatrics
Milton S. Hershey Medical Center
Pennsylvania State University
Hershey, Pennsylvania 17033

DISTRICT IV

Cornelia Morse Carithers, M.D., FAAP
1661 Riverside Avenue
Jacksonville, Florida 32204

DISTRICT V

Susan Scheurer, M.D., Candidate FAAP
B240 Life Sciences
Department of Human Development
Michigan State University
East Lansing, Michigan 48224

DISTRICT VI

Gerald Solomons, M.D., FAAP
Department of Pediatrics
University Hospital
Iowa City, Iowa 52242

Ben Rubin, Jr., M.D., FAAP
132 South Seventeenth Street
Kansas City, Kansas 66102

Thomas L. Cress, M.D., FAAP
37 North Twenty-eighth Avenue
St. Cloud, Minnesota 56301

Richard L. Dreher, M.D., FAAP
Children's Mercy Hospital
Twenty-fourth and Gillham Road
Kansas City, Missouri 64108

DISTRICT VI (continued)

Matilda McIntire, M.D., FAAP
Department of Pediatrics
Creighton University School of Medicine
Tenth and Castelar Streets
Omaha, Nebraska 68108

Lloyd Reiser, M.D., FAAP
P.O. Box 6001
1702 South University Drive
Fargo, North Dakota 58102

Eberhard H. Heinrichs, M.D., FAAP
320 Seventh Avenue, Southeast
Watertown, South Dakota 57201

Phillip Bond, M.D., FAAP
Milwaukee Children's Hospital
1700 West Wisconsin Avenue
Milwaukee, Wisconsin 53233

DISTRICT VII

Joan R. Hebeler, M.D., FAAP
Department of Pediatrics
University of Texas Medical Branch
Galveston, Texas 77550

DISTRICT VIII

Barton D. Schmitt, M.D., FAAP
Department of Pediatrics
University of Colorado Medical Center
4200 East Ninth Avenue
Denver, Colorado 80220

William M. Palmer, M.D., FAAP
Primary Children's Hospital Medical Center
320 Twelfth Avenue
Salt Lake City, Utah 84103

DISTRICT IX

David Belais Friedman, M.D., FAAP
Department of Pediatrics
University of Southern California School of Medicine
1200 North State Street
Los Angeles, California 90033

SUPPLEMENTARY AUDIO-VISUAL MATERIAL REVIEWED

*Indicates it was shown at one or more District VI workshops.

Association Films
512 Burlington Avenue
La Grange, Illinois 60525
312/352-3397

"Second Chance" (film) 16 mm/color/20 min./$10.50 rental (2 days)
"The War of the Eggs" (film) 16 mm/color or b&w/ 27 min./$18.95 rental (1 day-color) and $11.95 (1 day-b&w)

Brigham Young University
Educational Media Services
290 Herald R. Clark Building
Provo, Utah 84601
801/374-1211, ext. 2713

"Cipher in the Show" (film) 16 mm/color/24 min./ $14 rental per day plus $2 per day after day #1

University of Illinois
Visual Aids Service
1325 South Oak Street
Champaign, Illinois 61820
217/333-1360

"Children in Peril" (film) 16 mm/color/22 min./ $13 rental

Independent Order of Foresters
High Court of Southern California
100 Border Avenue, Suite B
Solana Beach, California 92075

"Fragile: Handle with Care" (film) 16 mm/color/ 20 min./ no rental fee

Indiana University Audio-Visual Center
Bloomington, Indiana 47401
812/337-2103

"The Battered Child" (film) 16 mm/b&w/58 min./ $15.25 rental

International Film Bureau
332 South Michigan Avenue
Chicago, Illinois 60604
312/427-4545

"The Neglected" (film) 16 mm/b&w/35 min./$15 rental for 1 to 3 day period

Louisiana State University
School of Medicine
Video-Cassette Service
1542 Tulane Avenue
New Orleans, Louisiana 70112
504/527-8138

"The Maltreatment Syndrome" (two 3/4" video-cassettes) b&w/Part I-60 min. and Part II-50 min./$35 each purchase

Medcom, Inc.
1633 Broadway
New York, New York 10019
212/765-6162

"The Battered Child Syndrome" (slide program) $75 purchase

Mike Williams Associates
P. O. Box 564
Manhattan Beach, California 90266
213/545-3512

*"Visual Diagnosis of Non-Accidental Trauma and Failure to Thrive (slide/tape) 35 mm/color/27 min./$10 preview to purchase, $35.50 purchase

"Pediatric Grand Rounds: A Case of Child Abuse" (3/4" videotape) b&w/50 min./$20 preview to purchase, $75 purchase

*"Acute Phase, Pediatric" (3/4" videotape) b&w/20 min./$10 preview to purchase, $39 purchase

*"Acute Phase, Consulting Pediatrician" (3/4" videotape) b&w/20 min./$10 preview to purchase $39 purchase

"Dispositional Conference" (3/4" videotape) b&w/30 min./$10 preview to purchase, $39 purchase

"Mother-Infant Interaction" (3/4" videotape) b&w/ 30 min./$10 preview to purchase, $39 purchase

J. Gary Mitchell Film Company, Inc.
2000 Bridgeway
Sausalito, California 94965
415/332-5760

"Child Abuse: Cradle of Violence" (film) 16 mm/ color/20 min./$50 rental (3 days)

"Incest: The Victim Nobody Believes" (film) 16 mm/ color/21 min./$50 rental (3 days)

Motorola Teleprograms, Inc.
4825 North Scott Street, Suite 23
Schiller Park, Illinois 60176
312/671-0141 or 800/323-1900

*"Don't Give Up on Me" (film) 16 mm/color/28 min./ $35 rental (3 days)

"Case Studies in Early Sexual Abuse" (film) 16 mm/ color/ two @ 25 min./$100 weekly rental

"Incest: The Last Taboo" (film) 16mm/color/25 min./ $60 weekly rental

Parents' Magazine Films, Inc.
52 Vanderbilt Avenue
New York, New York 10017
212/661-9080

"Children in Crisis: Child Abuse and Neglect" (five filmstrips with audio-cassettes) color/70 min./ $65 purchase

University of Texas Medical Branch
Galveston, Texas 77550
713/765-1011

*"High-Risk Family" (3/4" videotape) b&w/20 min./not commercially available

*"Schizophrenic Mother/Disturbed Parent-Child Relationship" (3/4" videotape) b&w/20 min./not commercially available

The following materials are part of the Focus: Child Abuse and Neglect curriculum developed for the National Institutes of Mental Health by the Oakland Children's Trauma Center. They were only recently reviewed, and are strongly recommended as supplementary material for training physicians. They are not yet available commercially.

"Medical Identification: Physician" (slide program)
"Initial Interview (film)
"Case Conference" (film)
"Physician in Court" (film)

APPENDIX E

ROSTER: LEGAL RESOURCE PERSONS

St. Louis, Missouri

Jessie Goldnar
Assistant Professor of Law
Saint Louis University
3700 Windol Boulevard
St. Louis, Missouri 63108

Wichita, Kansas

Jerry G. Elliott
Attorney at Law
Foulston, Siefkin, Powers & Eberhardt
700 Fourth Financial Center
Broadway at Douglas
Wichita, Kansas 67202

Iowa City, Iowa

Harold Young
Area Prosecutor
Attorney General's Office
Des Moines, Iowa 50309

Maywood, Illinois

Thomas Hanraham
Attorney at Law
Executive Director
Juvenile Protective Association
12 East Grand Avenue
Chicago, Illinois 60611

Omaha, Nebraska

Susan Bradley
Deputy County Attorney
Omaha Douglas Civic Center
1819 Farnam
Omaha, Nebraska 68102

Milwaukee, Wisconsin

Frank Crivello
Assistant District Attorney
Milwaukee County
821 West State Street
Milwaukee, Wisconsin 53233

Minneapolis, Minnesota

Edward C. Anderson
Assistant County Attorney
Hennepin County
20 A Government Center
Minneapolis, Minnesota 55487

Fargo, North Dakota

Wayne J. Anderson
Chief Legal Counsel
Social Services Board
Capitol Building
Bismarck, North Dakota 58501

Sioux Falls, South Dakota

Harry J. Christianson, Jr.
Deputy Attorney General
State of South Dakota
Capitol Building
Pierre, South Dakota 57501

Academy Spring Session Seminar -
New Orleans, Louisiana

Brian Fraser, J.D.
Executive Director
National Committee for Prevention
of Child Abuse
Suite 510
111 East Wacker Drive
Chicago, Illinois 60601

PRESIDENT
MERRITT B. LOW, M.D.
88 HIGH STREET
GREENFIELD, MASS. 01301
VICE PRESIDENT
DAVID W. VAN GELDER, M.D.
888 TARA BOULEVARD
BATON ROUGE, LOUISIANA 70806
EXECUTIVE DIRECTOR
ROBERT G. FRAZIER, M.D.
ASSOCIATE DIRECTOR
RICHARD W. OLMSTED, M.D.
SECRETARY
GERALD E. HUGHES, M.D.
TREASURER
GEORGE A. NAUMAN

American Academy of Pediatrics

P.O. BOX 1034 • EVANSTON, ILLINOIS 60204
EVANSTON (312) 869-4255 CHICAGO (312) 273-3646

DISTRICT CHAIRMEN
SPRAGUE W. HAZARD, M.D.
DEERFIELD, MASSACHUSETTS
MILTON GORDON, M.D.
HUNTINGTON, NEW YORK
WILLIAM A. HOWARD, M.D.
WASHINGTON, D.C.
EDWIN L. KENDIG, JR., M.D.
RICHMOND, VIRGINIA
BRUCE D. GRAHAM, M.D.
COLUMBUS, OHIO
R. DON BLIM, M.D.
KANSAS CITY, MISSOURI
BLAIR E. BATSON, M.D.
JACKSON, MISSISSIPPI
JAMES E. STRAIN, M.D.
DENVER, COLORADO
SAUL J. ROBINSON, M.D.
SAN FRANCISCO, CALIFORNIA
GUILLERMO GUILLEN-ALVAREZ, M.D.
SAN SALVADOR, EL SALVADOR
HELIO SEBASTIAO DE MARTINO, M.D.
RIO DE JANEIRO, BRASIL
JOSE MARIA ALBORES, M.D.
BUENOS AIRES, ARGENTINA

SPECIAL ATTENTION
ACTION NEEDED

MEMORANDUM

To: AAP Fellows in District VI
From: R. Don Blim, M.D. R Don Blim, MD 2H for
RE: Invitation To Participate In Workshop On Child Abuse and Neglect
Date: September 15, 1976

The Academy has received a $98,000 grant from the National Center on Child Abuse and Neglect to develop a one-year demonstration project for continuing education to physicians in identifying, reporting, referral and inter-disciplinary coordination of cases of child abuse and neglect.

The NCCAN was established through the 1974 Child Abuse Prevention and Treatment Act, which authorized the Center to award grants and enter into contracts "for development and establishment of training programs for professional and para-professional personnel in the fields of medicine, law, education, social work and other relevant fields who are engaged in, or intend to work in the fields of prevention, identification and treatment of child abuse and neglect." In accordance with this emphasis a training curriculum was developed by the NCCAN which is now ready for demonstration in the field.

The objectives of the demonstration projects are (1) to demonstrate and evaluate the effectiveness of the curriculum and (2) to evaluate a variety of methods employed by

professional associations to disseminate and utilize the curriculum.

In connection with the grant a series of one-day workshops will be offered at selected hospitals and medical schools throughout District VI from January through May of 1977. Proposed sites for the workshops are as follows:

Chicago
Milwaukee
Minneapolis
Fargo
Sioux Falls
Davenport
Omaha
Wichita
St. Louis

The content of these workshops will be based upon the NCCAN curriculum and supplemented with other materials. Workshop leaders will be Academy Fellows who have received training in the curriculum.

There will be no charge to participants, who will receive Category I credit for the Physician Recognition Award of the American Medical Association.

AAP Fellows in District VI are invited to indicate their interest in attending one of these workshops on the enclosed interest card.

Enrollment in each workshop will be limited to 20 participants.

APPENDIX G-1:GENERAL PRE-TEST QUESTIONNAIRE

(RESPONDENT NAME)

_____

(Please print your name on this line.)

THIS COVER SHEET HAS BEEN ATTACHED TO ENSURE PROPER DISTRIBUTION OF THE QUESTIONNAIRE. IT WILL BE REMOVED AND DESTROYED BEFORE THE QUESTIONNAIRE IS REVIEWED FOR CONTENT.

Workshop Code_____
Participant Number_____

NATIONAL CENTER ON CHILD ABUSE AND NEGLECT
DEMONSTRATION TRAINING PROGRAM
QUESTIONNAIRE

The American Academy of Pediatrics (AAP) is assisting the National Center on Child Abuse and Neglect (NCCAN) in evaluating the effectiveness of the medical unit of a curriculum on child abuse and neglect. To accomplish this task individuals who participate in the training programs are being asked to complete the following questionnaire. The information provided by this questionnaire will help AAP and NCCAN obtain useful feedback concerning this curriculum. Before the curriculum is made available for distribution on a large scale, NCCAN will revise this version of it. Changes in the medical unit will be based upon AAP's evaluation of the materials.

We greatly appreciate your cooperation in this effort. Please complete the questionnaire to the best of your ability. Your responses will be held in strict confidence and will not be associated with your name or the name of your organization or agency.

INSTRUCTIONS

THE QUESTIONS IN THIS INTERVIEW ARE DIRECTED AT VARIOUS ASPECTS OF CHILD ABUSE AND NEGLECT OTHER THAN DIRECT TREATMENT. PLEASE COMPLETE EACH ITEM BY CHECKING THE APPROPRIATE CATEGORY OR FILLING IN THE SPACE PROVIDED. WORDS IN CAPITOL LETTERS AT THE END OF SOME ITEMS ARE SPECIAL INSTRUCTIONS TO YOU. THE ENTIRE INTERVIEW SHOULD TAKE NO MORE THAN 20 MINUTES OF YOUR TIME.

THANK YOU AGAIN FOR YOUR COOPERATION!

American Academy of Pediatrics
1801 Hinman Avenue
Evanston, Illinois 60204

Please indicate how you feel about the statements below:

(1) STRONGLY AGREE
(2) AGREE
(3) ARE UNCERTAIN
(4) DISAGREE
(5) STRONGLY DISAGREE

1. Society contributes to child abuse and neglect by expecting parents to nurture and support children with little or no training.	1	2	3	4	5
2. All parents can be considered potential child abusers.	1	2	3	4	5
3. Parents who physically abuse their children are mostly from lower socio-economic levels.	1	2	3	4	5
4. Most cases of child abuse and neglect cannot be prevented.	1	2	3	4	5
5. In an interview with a parent suspected of child abuse and neglect it is important for the social worker, physician or health professional to focus the interview on the child rather than on the parent.	1	2	3	4	5
6. Health professionals are reluctant to admit to themselves that anyone, particularly a regular patient, could abuse a child.	1	2	3	4	5
7. Physicians often deny the existence of child abuse.	1	2	3	4	5
8. Mandatory reporting laws place the physician or health professional in a difficult position because they force him/her to violate the confidence of the patient in the privileged doctor-client relationship.	1	2	3	4	5
9. Reporting a suspected case of child abuse to the authorities is being responsive to the parent's plea for help.	1	2	3	4	5
10. The question of whether or not a particular child abuse case should be reported should be left to the discretion of the attending physician.	1	2	3	4	5
11. Unless conclusive evidence of abuse or neglect exists, reporting a suspected case of child abuse or neglect is an irresponsible act.	1	2	3	4	5
12. The difficulties involved in having to go to court contribute to under-reporting of child abuse cases by physicians.	1	2	3	4	5
13. Courts should not be able to subpoena a physician's records in a child abuse case.	1	2	3	4	5

14. Children who have suffered abuse or neglect from their parents should be removed from the home permanently to prevent future physical or emotional trauma. 1 2 3 4 5

15. Parents who abuse or neglect their children should be prosecuted to the fullest extent possible. 1 2 3 4 5

16. Listed below are selected characteristics which might describe abusive parents. Mark those which, in your experience, apply to MOST parents who abuse their children.

( ) do not want their children
( ) psychotic
( ) introspective
( ) experiences intense anger
( ) idealistic
( ) motivated to change their abusive behavior
( ) overprotective of child
( ) sees child as extension of his/her self
( ) intelligent
( ) has difficulty expressing needs
( ) immature
( ) lacked nurturing in childhood
( ) socially active
( ) views child's dependency needs as demands
( ) abused by own parents
( ) expects too much of their children
( ) impulsive
( ) trusts others
( ) was never able to please parents
( ) tolerant of frustration
( ) feels inadequate
( ) will not allow child to be self-sufficient
( ) resourceful
( ) isolated
( ) suppresses communication of feelings
( ) anxious
( ) self-destructive

17. Which of the following characteristics describe MOST abused children with whom you have had contact?

( ) do not enjoy play activities
( ) have a very poor self- concept
( ) are extremely aggressive
( ) are extremely compliant
( ) are very concerned about meeting parent's needs
( ) are very dependent
( ) are wary of physical contact
( ) have short attention span
( ) have frequent temper tantrums
( ) are extremely self- controlled
( ) are immobile
( ) are inordinately shy
( ) are inhibited in verbal or crying responses
( ) are very compulsive
( ) display generalized fearfulness

The following items have been mentioned by physicians as obstacles to identification referral and treatment of individuals who abuse or neglect their children. Would you please rate each item as it relates to your own experience by circling the appropriate number.

1 - Not important obstacle
2 - Present, but not serious obstacle
3 - Serious obstacle
4 - Not applicable in my experience

18.	fear civil or criminal liability for reporting	1	2	3	4
19.	believe that reporting is not part of my professional responsibility	1	2	3	4
20.	positive diagnosis of child abuse and neglect is difficult	1	2	3	4
21.	fear making an unjustified report	1	2	3	4
22.	object to the time and paper work involved in reporting and following up a report	1	2	3	4
23.	am unwilling to testify in court	1	2	3	4
24.	do believe that few cases of child abuse and neglect occur in my community	1	2	3	4
25.	believe that it is best to handle such problems alone.	1	2	3	4
26.	believe that the family or individuals involved will be unjustly stigmatized	1	2	3	4
27.	do not wish to destroy a professional relationship with a client/patient	1	2	3	4
28.	am unwilling to report middle and upper-income families	1	2	3	4
29.	believe that reporting is ineffectual, that no help will be provided to the family	1	2	3	4
30.	do not wish to breach the confidentiality of privileged communications	1	2	3	4
31.	feel the community response to reports of suspected cases is too punitive	1	2	3	4
32.	am uncertain what the community response to such a report would be	1	2	3	4
33.	am unwilling to accept sole responsibility for making such a report	1	2	3	4
34.	do not have adequate information on the state reporting laws	1	2	3	4

In the first three columns of the table below, please rate yourself in terms of your knowledge of the various activities related to cases of child abuse and neglect. (BENEATH THE TABLE ARE BRIEF DEFINITIONS OF EACH OF THE ACTIVITIES. CHECK THE APPROPRIATE BOX ON EACH LINE). In the last three columns of the table rate yourself in terms of your confidence to perform the various activities. (CHECK THE APPROPRIATE BOX ON EACH LINE)

DEFINITION OF ACTIVITIES: Identification means finding and recognizing cases of child abuse and neglect after they have occurred.
Reporting means bringing to official attention cases of child abuse and neglect that have been identified.
Referral means linking families involved in child abuse and neglect with the resources they need.
Case Management means maintaining an on-going involvement with cases of child abuse and neglect throughout the duration of treatment.

		(1)	(2)	(3)	(1)	(2)	(3)
	Activity	High Degree of Knowledge	Moderate Degree of Knowledge	Little Knowledge	High Confidence	Moderate Confidence	Little Confidence
35.	Identification of Physical Abuse						
36.	Identification of Emotional Maltreatment						
37.	Identification of Sexual Abuse						
38.	Identification of Neglect						
39.	Reporting						
40.	Referral						
41.	Case Management						

In terms of your knowledge of the following topics related to child abuse and neglect, how would you rate yourself using the table below? (CHECK THE APPROPRIATE BOX ON EACH LINE)

	TOPIC AREA	(1) High Degree of Knowledge	(2) Moderate Degree of Knowledge	(3) Little Knowledge
42.	Reporting obligations of my state law			
43.	Legal Safeguards, if any, which protect me from liability			
44.	Procedures for interagency referral of child abuse and neglect			
45.	Procedures to report a case of child abuse or neglect			
46.	Legal definition of physical abuse in my jurisdiction			

How would you rate your understanding of the role the following organizations or individuals in your community actually play in regard to cases of child abuse and neglect? (CHECK THE APPROPRIATE BOX ON EACH LINE)

	ORGANIZATIONS AND INDIVIDUALS	(1) Good Understanding	(2) Moderate Understanding	(3) Little Understanding
47.	Police department			
48.	Schools			
49.	Day care centers			
50.	Mental health centers			
51.	Hospitals			
52.	Public health departments			
53.	Social service departments			
54.	Private physicians			

In terms of your confidence to perform the following activities related to a case of child abuse and neglect, how would you rate yourself using the table below? (CHECK THE APPROPRIATE BOX ON EACH LINE)

	ACTIVITY	(1) High Confidence	(2) Moderate Confidence	(3) Little Confidence
55.	To counsel an abusive (or potentially abusive) parent to accept help			
56.	To assess family needs			
57.	To develop a treatment plan			
58.	To follow through with other persons or agencies			
59.	To prepare for court and court testimony			
60.	To provide court testimony			
61.	To convey information on child abuse and neglect to others engaged in work with abused/neglected children			
62.	To discuss a case of child abuse and neglect with my colleagues			

IN THE QUESTIONS WHICH FOLLOW PLEASE CHECK THE APPROPRIATE CATEGORY TO INDICATE VARIOUS ASPECTS OF YOUR BACKGROUND AND TRAINING:

63. What is your profession:

___Physician in practice
___pediatrician
___family practice physician
___emergency room physician
___general practice physician
___other_____

___sub-specialty, if applicable_____

___Resident
specialty_____

___Intern

___Medical School Student

(Circle appropriate year) 1 2 3 4

64. For how many years have you practiced your profession?

1 year or less _____
2 - 5 years _____
6 - 10 years _____
10 - 20 years _____
More than 20 years _____

65. With what agency or organization are you primarily affiliated? (CHECK APPROPRIATE BOXES TO INDICATE TYPE OF AGENCY OR ORGANIZATION.)

AGENCY	(1) State Government	(2) County Government	(3) City or Local Gov.	(4) Private
Self-employed				
Clinic				
Hospital				
College of University				
Health Department				
School System				
Social Services Department				
Voluntary Agency				
Police Department				
District Attorney's Office				
Public Defender's Office				
Courts				
Other (specify:_____)				

66. Please state your job title and briefly describe your specific job responsibilities. Also provide the number of individuals under your direct supervision, other than clerical or secretarial personnel, in the space provided.

Job title:_____

Major job responsibilities_____

_____

Number of individuals under your supervision:_____

67. What is the approximate number of suspected cases of child abuse and neglect with which you have been substantially involved as part of your job during the last year?

(1)_____None
(2)_____Under 10
(3)_____10-20
(4)_____21-50
(5)_____51-100
(6)_____Over 100

68. What do your specific job responsibilities include with respect to cases of child abuse and neglect? (CHECK AS MANY AS APPLY)

DEFINITION OF ACTIVITIES:

Identification means finding and recognizing cases of child abuse and neglect after they have occurred.
Reporting means bringing to official attention cases of child abuse and neglect that have been identified.
Referral means linking families involved in child abuse and neglect with the resources they need.
Case management means maintaining an on-going involvement with cases of child abuse and neglect throughout the duration of treatment.

(1)_____Identification
(2)_____Reporting
(3)_____Referral
(4)_____Case management
(5)_____Treatment
(6)_____Providing court testimony
(7)_____Other (Please specify:_____)

69. What is the approximate number of suspected cases of child abuse and neglect which you have reported during the past year?

(1)_____None
(2)_____Under 10
(3)_____10-20
(4)_____21-50
(5)_____51-100
(6)_____Over 100

70. What is the approximate number of suspected cases of child abuse and neglect in which you have served as an expert witness?

(1)_____None
(2)_____Under 10
(3)_____10 - 20
(4)_____21 - 50
(5)_____51 - 100
(6)_____Over 100

71. In the table below, please indicate whether your agency/organization has legal accountability for the various activities related to child abuse and neglect. (CHECK THE APPROPRIATE BOX ON EACH LINE. IF YOU DO NOT WORK FOR AN AGENCY/ORGANIZATION, CHECK THE BOX BELOW THE TABLE.)

	Yes	No	Don't know
Reporting			
Referral			
Case Management			
Treatment			

☐ Don't work for agency/organization

72. In the table below please indicate the composition of your client population according to their racial and ethnic characteristics. (GIVE YOUR ESTIMATE BY CHECKING THE APPROPRIATE BOX ON EACH LINE.)

	0-25%	26-50%	51-75%	76-100%
White				
Black				
Native American				
Hispanic American				
Asian American				

73. Please indicate in the space provided the approximate population of the town or city where you work.

___Under 1000
___1000-2500
___2500-5000
___5000-10,000
___10,000-25,000
___25,000-50,000
___50,000-100,000
___100,000-250,000
___250,000-500,000
___500,000-1,000,000
___1,000,000 and over

74. Which of the following social class groupings best describe the economic status of most of your clientele? (PUT A "1" NEXT TO THE CATEGORY WHICH DESCRIBES THE GROUP WITH WHICH YOU ARE MOST SUBSTANTIALLY INVOLVED, A "2" NEXT TO THE GROUP WITH WHICH YOU HAVE THE SECOND GREATEST INVOLVEMENT.)

(1)_____Upper income
(2)_____Upper middle income
(3)_____Lower middle income
(4)_____Lower income
(5)_____Don't know

75. Does your professional work include substantial involvement with military families:

_____Yes _____No

76. Did you volunteer for the sessions you are now attending or was your participation determined by someone else?
_____Volunteered to participate
_____Participation determined by someone else

In the first two columns of the table below, please check the type(s) of training you have received previously that was specifically designed to improve your understanding and/or skills related to cases of child abuse and neglect. In the last five columns of the table, indicate what topic areas were covered in the training you received. (PLACE CHECKS IN THE LAST FIVE COLUMNS ONLY FOR THOSE TYPES OF TRAINING CHECKED IN THE FIRST TWO COLUMNS. IF YOU HAVE NEVER RECEIVED SPECIFIC TRAINING PREVIOUSLY, THERE SHOULD BE NO CHECKS IN THE LAST FIVE COLUMNS)

	TYPE OF TRAINING	(1) Yes	(2) No	Topic Areas Included (3) Identification	(4) Reporting	(5) Referral	(6) Case Management	(7) Treatment
77.	Formal College or University Course							
78.	Formal Training Course Offered by Employer							
79.	On-the-Job Training							
80.	Employer Sponsored Seminar or Conference							
81.	Non-Work Affiliated Seminar or Conference							
82.	Other (please spedify): _____							

FOR STATISTICAL PURPOSES ONLY, PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT YOURSELF (CHECK THE APPROPRIATE CATEGORY OR FILL IN THE SPACE PROVIDED)

83. Sex:
(1)___Male
(2)___Female

84. Age Group:

(1)___Under 25	(5)___40-44
(2)___25-29	(6)___45-49
(3)___30-34	(7)___50-59
(4)___35-39	(8)___60 and over

85. Racial or ethnic group:

(1)___White
(2)___Black
(3)___Native American
(4)___Hispanic American
(5)___Asian American

86. Number of own children:_____

87. What is the most important problem you face in dealing with child abuse and neglect which <u>does</u> <u>not</u> concern treatment that you hope will be addressed by this training course? (TRY TO BE AS SPECIFIC AS POSSIBLE)

_____
_____
_____

APPENDIX G-2:CONTENT PRE-TEST QUESTIONNAIRE

(RESPONDENT NAME)

_____

(Please print your name on this line.)

THIS COVER SHEET HAS BEEN ATTACHED TO ENSURE PROPER DISTRIBUTION OF THE QUESTIONNAIRE. IT WILL BE REMOVED AND DESTROYED BEFORE THE QUESTIONNAIRE IS REVIEWED FOR CONTENT.

Workshop Code_____
Participant Number_____

NATIONAL CENTER ON CHILD ABUSE AND NEGLECT
DEMONSTRATION TRAINING PROGRAM
QUESTIONNAIRE

The American Academy of Pediatrics (AAP) is assisting the National Center on Child Abuse and Neglect (NCCAN) in evaluating the effectiveness of the medical unit of a curriculum on child abuse and neglect. To accomplish this task individuals who participate in the training programs are being asked to complete the following questionnaire. The information provided by this questionnaire will help AAP and NCCAN obtain useful feedback concerning this curriculum. Before the curriculum is made available for distribution on a large scale, NCCAN will revise this version of it. Changes in the medical unit will be based upon AAP's evaluation of the materials.

We greatly appreciate your cooperation in this effort. Please complete the questionnaire to the best of your ability. Your responses will be held in strict confidence and will not be associated with your name or the name of your organization or agency.

INSTRUCTIONS

THE QUESTIONS IN THIS INTERVIEW ARE DIRECTED AT VARIOUS ASPECTS OF CHILD ABUSE AND NEGLECT OTHER THAN DIRECT TREATMENT. PLEASE COMPLETE EACH ITEM BY CHECKING THE APPROPRIATE CATEGORY OR FILLING IN THE SPACE PROVIDED. WORDS IN CAPITOL LETTERS AT THE END OF SOME ITEMS ARE SPECIAL INSTRUCTIONS TO YOU. THE ENTIRE INTERVIEW SHOULD TAKE NO MORE THAN 20 MINUTES OF YOUR TIME.

THANK YOU AGAIN FOR YOUR COOPERATION!

American Academy of Pediatrics
1801 Hinman Avenue
Evanston, Illinois 60204

88. Child abuse is the most common cause of death in children at which of the following ages?
    a. 1-5 months
    b. 6-12 months
    c. 13-18 months
    d. 19-24 months
    e. 24-30 months

89. The most important diagnostic finding in child abuse is:
    a. multiple fractures
    b. burns
    c. bruises
    d. multiple injuries at different stages of healing
    e. weight below 3rd percentile and height well above 3rd percentile on growth curve

90. All of the following may be signs of child abuse EXCEPT:
    a. pancreatic pseudocysts
    b. avulsion of the common bile duct
    c. retinal hemorrhage
    d. vulvar edema
    e. urethral caruncle

91. Which of the following skin lesions is NOT commonly associated with child abuse:
    a. ecchymosis
    b. laceration
    c. petechiae
    d. rope burns
    e. "glove" or "stocking" immersion burns

92. All of the following can be confused with child abuse and neglect EXCEPT:
    a. mongolian spots
    b. Von Willebrandt's Disease (hemophilia)
    c. bullous impetigo
    d. toxic epidermal necrolysis
    e. subluxation of the head of the radius

93. A six-month old infant is brought into the emergency room by his mother with the complaint that he has become fussy and irritable over the course of the day. He was apparently well yesterday, but today has not felt well. The mother says he has always been difficult to care for, "but then, so were my other 3 children." On examination the child is clean but looks somewhat undernourished. He is irritable and difficult to examine, and does not quiet down when you try to comfort him. There is a series of linear bruises on the left side of the face, and the left side of the mouth and ear are swollen. The fontanel is full but not bulging. In response to your inquiry the mother says the two-year old sister hit the baby yesterday.

At this point you would:

a. call the appropriate authorities and report the case as child abuse
b. order skull x-rays and a long-bone series
c. tell the mother you don't believe her story and accuse her of battering her child
d. spend some time talking with the mother to explore the family and social situation more fully
e. discharge the child home with instructions to the mother on how to care for the child.

94. The skull x-rays reveal minimal separation of all sutures with no fractures seen. No fractures or other evidence of bone injury are seen on the extremity films. At this point you feel it BEST to:

a. admit the child to the hospital for further observation and management
b. discharge the child home with a return visit scheduled in three days
c. tell the mother you don't believe her story and accuse her of battering her child
d. call the appropriate authorities and report the case as child abuse
e. obtain a neurosurgical consultation before proceeding further.

95. You are taking a call in an emergency room. The nurse calls to see Mr. and Mrs. Johnson who have a 7 month old baby with fever. They have been sitting in the emergency room for an hour but did not ask to be seen until the nurse approached them. The nurse tells you the baby looks very ill.

Vital signs: temp. 102^0 R.R. 64. p.r. 130
C.C. Cough and fever for 3 days
Physical examination:
Irritable infant with cough. Fontanel flat. Both tympanic membranes are red and full. Crepitant rales are present on the right anterior chest. There is an area of crepitation when the stethoscope is placed on the right chest. This is confirmed by palpation.
Lab: Chest x-ray. Infiltrate on the right lower lobe, six rib fractures on the right side.
CBC Hgb 10 gms WBC 16,800 PMNs 80 Bands 3 Lymphs 7

You ask the family about the fractured ribs and are told a 2 year old sibling dropped an evaporated milk can on the baby's chest.

The MOST appropriate action at this time is:

a. treat the child's otitis and pneumonia and send him home
b. call the police and hold the child in the emergency room
c. admit the child to the hospital
d. call the protective service agency
e. obtain an x-ray, skeletal survey for other fractures

96. Inflicted bruises occur commonly in all of the following sites EXCEPT the:

a. genitals
b. buttocks
c. upper lip
d. wrist
e. cheek

97. True statements about abdominal injuries in cases of child abuse include all of the following EXCEPT:

a. they are the most common non-accidental injuries
b. they are rarely asymptomatic
c. they may produce medical emergencies in affected children
d. they account for 20% of the deaths of children from non- accidental injury
e. Children with abdominal injuries may present with absent bowel sounds.

98. The MOST common intra-abdominal injury in non-accidental injury is:
    a. laceration or rupture of the intestines
    b. laceration or rupture of the liver or spleen
    c. intramural hematoma of the duodenum or jejunum
    d. rupture of the inferior vena cava
    e. laceration of the pancreas

99. X-ray findings strongly suggestive of non-accidental injury include all of the following EXCEPT:
    a. metaphysial fracture
    b. epiphysial separation
    c. multiple fractures of the same age
    d. multiple fractures of different ages
    e. subperiosteal calcification

100. Head shaking can result in all of the following EXCEPT:
    a. retinal detachment
    b. vitreous hemorrhages
    c. subdural hematomas
    d. Bell's palsy
    e. whiplash

101. A battered child has complained of pain and tenderness of the rib cage. Initial x-rays of the ribs are reported to show no evidence of fractures. The patient should be re-x-rayed in:
    a. 7-10 days
    b. 14 days
    c. 4 weeks
    d. never

102. A three year old child who has a swollen left arm and is suspected of having been abused should have the following x-rays:
    a. left humerus
    b. left upper extremity to include shoulder
    c. total body
    d. long bones
    e. both hands and chest

103. True statements about sexual abuse in children include all of the following EXCEPT:
    a. The emotional impact may be more important than any physical injury sustained.
    b. A clear history is difficult to obtain from the victim.
    c. The alleged perpetrator is most commonly a parent or other family member.
    d. Physical findings on the child usually establish the diagnosis of assault.
    e. Venereal disease may be a co-existing condition.

104. During the acute phase interview with the parents in a case of suspected child abuse, the physician should do the following: (More than one answer is correct.)

a. gather medical, sociological data with which to determine a course of action for intervention with the family.
b. accept and record the details of how the injury allegedly occurred.
c. elicit a confession.
d. advise the parents of their rights.
e. establish rapport for ongoing relationships with the family.

105. Historical data from abusive families include all of the following EXCEPT:

a. isolation
b. excessively high expectation of their children
c. low self esteem
d. expectation of personal failure
e. income usually below $5,000

106. The initial interview with the family member suspected of abusing a child is best handled by:

a. the police
b. the resident on call
c. the child's own doctor
d. the psychiatrist on call
e. the Protective Services doctor

107. Indicate which of the following are sound principles for conducting an acute phase interview: (More than one selection may be correct.)

a. It is advisable that the interviewer define for the parents his/her role in relation to the criminal justice system.
b. An accusatory approach to questioning is recommended in order to penetrate the defenses of the parent.
c. It is not necessary to inform parents that answers to any questions or statements they might make will be on the record.
d. The interviewer should observe the client's behavior closely for clues that information is being implied rather than stated outright.
e. It is important that the questions be formulated in language which parents can understand easily.

108. Which of the following elements of a medical history is MOST diagnostic of child abuse?

a. Parents are vague in explaining the cause of the child's injuries.
b. Dating of injuries by parent differs from clinical dating.
c. Parents delay in seeking medical care for child's injuries.
d. Parents allege that injury was inflicted by a third party.
e. Parents allege that injury was self-inflicted.

109. Please indicate the state where you see most of your patients:

_____Missouri
_____Kansas
_____Illinois
_____Iowa
_____Nebraska
_____Wisconsin
_____Minnesota
_____South Dakota
_____North Dakota
_____Other_____

110. How would you summarize the reporting obligations of your state law in cases of child abuse and neglect? (IF YOU DO NOT KNOW THE EXACT WORDING, STATE THE REPORTING OBLIGATIONS AS BEST YOU CAN USING YOUR OWN WORDS.)

a. Who must report:_____
_____
b. What must be reported:_____
_____
c. To whom must reports be made:_____
_____

111. What legal safeguards, if any, protect you from liability in such cases?

_____
_____
_____

112. What are the procedures for interagency referral of child abuse and neglect cases in your community?_____
_____
_____

113. What is the legal definition of physical abuse in your state? (IF YOU DO NOT KNOW THE EXACT WORDING, STATE THE DEFINITION AS BEST YOU CAN USING YOUR OWN WORDS.)

_____
_____
_____

114. Does your state law explicitly refer to emotional maltreatment as a reportable form of child abuse?

_____Yes
_____No
_____Don't know

Please complete the following items by checking the appropriate category:

1 - True
2 - False
9 - Don't know

115. In some states hearsay evidence is admissable in court if made by those directly involved in the case. 1 2 9

116. The physician may refuse to testify in court in a child abuse case because of the law of confidentiality between physician and patient. 1 2 9

117. The medical records of an examining physician may not be subpoened. 1 2 9

118. The physician must memorize the facts before testifying. 1 2 9

119. The physician may use x-rays and photographs in his/her testimony. 1 2 9

120. The physician, as an expert witness, may say anything s/he wishes in court regarding his/her medical opinions. 1 2 9

121. The physician may not make statements as to who injured the child. 1 2 9

122. The main legal risk for a physician involved in a child abuse case is:

a. a criminal suit for failure to report
b. a civil suit for reporting an unconfirmed case
c. a civil suit for failure to report a suspected case
d. a civil suit for breaking the parent's right to confidentiality in privileged communications.

123. The juvenile court can (more than one answer may be correct):
   a. determine guilt or innocence of accused
   b. remove the child from the home
   c. jail the parent
   d. fine the parents
   e. order that parent(s) obtain counseling or other social services

124. The physician's testimony is MAINLY needed at the:
   a. dispositional hearing
   b. temporary custody hearing
   c. review hearing
   d. adjudicatory hearing
   e. petition

125. Which of the following describe the role of criminal courts in cases of child abuse and neglect? (More than one response may be correct.)
   a. has some authority to make orders concerning the child victim
   b. may mandate social services for the defendant as terms of probation
   c. may levy fine if defendant is found guilty
   d. protects constitutional rights of parents and children
   e. may imprison a convicted defendant

126. In a criminal court the prosecution must show:
   a. preponderance of evidence
   b. evidence beyond all reasonable doubt
   c. probable cause
   d. reasonable likelihood

127. Which of the following defense attorney strategies is a medical witness likely to encounter during cross-examination? (More than one answer may be correct.)

   a. Physician may be attacked for failure to perform all medical tests needed to eliminate conclusively the possibility of natural causes for some of the child's injuries.
   b. Physician may be questioned on the degree of certainty with which s/he is able to diagnose child abuse and neglect.
   c. Physician's level of expertise in area of child abuse and neglect may be questioned.
   d. Physician may be questioned about each specific injury separately, trying to suggest that each injury, by itself, might have been accidental.
   e. Defense attorney may attempt to provoke physician to anger or defensiveness.

(RESPONDENT NAME)

_____

(Please print your name on this line.)

THIS COVER SHEET HAS BEEN ATTACHED TO ENSURE PROPER DISTRIBUTION OF THE QUESTIONNAIRE. IT WILL BE REMOVED AND DESTROYED BEFORE THE QUESTIONNAIRE IS REVIEWED FOR CONTENT.

Workshop Code_____
Participant Number_____

NATIONAL CENTER ON CHILD ABUSE AND NEGLECT
DEMONSTRATION TRAINING PROGRAM
QUESTIONNAIRE

The American Academy of Pediatrics (AAP) is assisting the National Center on Child Abuse and Neglect (NCCAN) in evaluating the effectiveness of the medical unit of a curriculum on child abuse and neglect. To accomplish this task individuals who participate in the training programs are being asked to complete the following questionnaire. The information provided by this questionnaire will help AAP and NCCAN obtain useful feedback concerning this curriculum. Before the curriculum is made available for distribution on a large scale, NCCAN will revise this version of it. Changes in the medical unit will be based upon AAP's evaluation of the materials.

We greatly appreciate your cooperation in this effort. Please complete the questionnaire to the best of your ability. Your responses will be held in strict confidence and will not be associated with your name or the name of your organization or agency.

INSTRUCTIONS

THE QUESTIONS IN THIS INTERVIEW ARE DIRECTED AT VARIOUS ASPECTS OF CHILD ABUSE AND NEGLECT OTHER THAN DIRECT TREATMENT. PLEASE COMPLETE EACH ITEM BY CHECKING THE APPROPRIATE CATEGORY OR FILLING IN THE SPACE PROVIDED. WORDS IN CAPITOL LETTERS AT THE END OF SOME ITEMS ARE SPECIAL INSTRUCTIONS TO YOU. THE ENTIRE INTERVIEW SHOULD TAKE NO MORE THAN 20 MINUTES OF YOUR TIME.

THANK YOU AGAIN FOR YOUR COOPERATION!

American Academy of Pediatrics
1801 Hinman Avenue
Evanston, Illinois 60204

Please indicate how you feel about the statements below:

(1) STRONGLY AGREE
(2) AGREE
(3) ARE UNCERTAIN
(4) DISAGREE
(5) STRONGLY DISAGREE

1. Society contributes to child abuse and neglect by expecting parents to nurture and support children with little or no training.	1	2	3	4	5
2. All parents can be considered potential child abusers.	1	2	3	4	5
3. Parents who physically abuse their children are mostly from lower socio-economic levels.	1	2	3	4	5
4. Most cases of child abuse and neglect cannot be prevented.	1	2	3	4	5
5. In an interview with a parent suspected of child abuse and neglect it is important for the social worker, physician or health professional to focus the interview on the child rather than on the parent.	1	2	3	4	5
6. Health professionals are reluctant to admit to themselves that anyone, particularly a regular patient, could abuse a child.	1	2	3	4	5
7. Physicians often deny the existence of child abuse.	1	2	3	4	5
8. Mandatory reporting laws place the physician or health professional in a difficult position because they force him/her to violate the confidence of the patient in the privileged doctor-client relationship.	1	2	3	4	5
9. Reporting a suspected case of child abuse to the authorities is being responsive to the parent's plea for help.	1	2	3	4	5
10. The question of whether or not a particular child abuse case should be reported should be left to the discretion of the attending physician.	1	2	3	4	5
11. Unless conclusive evidence of abuse or neglect exists, reporting a suspected case of child abuse or neglect is an irresponsible act.	1	2	3	4	5
12. The difficulties involved in having to go to court contribute to under-reporting of child abuse cases by physicians.	1	2	3	4	5
13. Courts should not be able to subpoena a physician's records in a child abuse case.	1	2	3	4	5

14. Children who have suffered abuse or neglect from their parents should be removed from the home permanently to prevent future physical or emotional trauma. 1 2 3 4 5

15. Parents who abuse or neglect their children should be prosecuted to the fullest extent possible. 1 2 3 4 5

16. Listed below are selected characteristics which might describe abusive parents. Mark those which, in your experience, apply to MOST parents who abuse their children.

( ) do not want their children
( ) psychotic
( ) introspective
( ) experiences intense anger
( ) idealistic
( ) motivated to change their abusive behavior
( ) overprotective of child
( ) sees child as extension of his/her self
( ) intelligent
( ) has difficulty expressing needs
( ) immature
( ) lacked nurturing in childhood
( ) socially active
( ) views child's dependency needs as demands
( ) abused by own parents
( ) expects too much of their children
( ) impulsive
( ) trusts others
( ) was never able to please parents
( ) tolerant of frustration
( ) feels inadequate
( ) will not allow child to be self-sufficient
( ) resourceful
( ) isolated
( ) suppresses communication of feelings
( ) anxious
( ) self-destructive

17. Which of the following characteristics describe MOST abused children with whom you have had contact?

( ) do not enjoy play activities
( ) have a very poor self- concept
( ) are extremely aggressive
( ) are extremely compliant
( ) are very concerned about meeting parent's needs
( ) are very dependent
( ) are wary of physical contact
( ) have short attention span
( ) have frequent temper tantrums
( ) are extremely self- controlled
( ) are immobile
( ) are inordinately shy
( ) are inhibited in verbal or crying responses
( ) are very compulsive
( ) display generalized fearfulness

The following items have been mentioned by physicians as obstacles to identification referral and treatment of individuals who abuse or neglect their children. Would you please rate each item as it relates to your own experience by circling the appropriate number.

1 - Not important obstacle
2 - Present, but not serious obstacle
3 - Serious obstacle
4 - Not applicable in my experience

18.	fear civil or criminal liability for reporting	1	2	3	4
19.	believe that reporting is not part of my professional responsibility	1	2	3	4
20.	positive diagnosis of child abuse and neglect is difficult	1	2	3	4
21.	fear making an unjustified report	1	2	3	4
22.	object to the time and paper work involved in reporting and following up a report	1	2	3	4
23.	am unwilling to testify in court	1	2	3	4
24.	do believe that few cases of child abuse and neglect occur in my community	1	2	3	4
25.	believe that it is best to handle such problems alone.	1	2	3	4
26.	believe that the family or individuals involved will be unjustly stigmatized	1	2	3	4
27.	do not wish to destroy a professional relationship with a client/patient	1	2	3	4
28.	am unwilling to report middle and upper-income families	1	2	3	4
29.	believe that reporting is ineffectual, that no help will be provided to the family	1	2	3	4
30.	do not wish to breach the confidentiality of privileged communications	1	2	3	4
31.	feel the community response to reports of suspected cases is too punitive	1	2	3	4
32.	am uncertain what the community response to such a report would be	1	2	3	4
33.	am unwilling to accept sole responsibility for making such a report	1	2	3	4
34.	do not have adequate information on the state reporting laws	1	2	3	4

In the first three columns of the table below, please rate yourself in terms of your knowledge of the various activities related to cases of child abuse and neglect. (BENEATH THE TABLE ARE BRIEF DEFINITIONS OF EACH OF THE ACTIVITIES. CHECK THE APPROPRIATE BOX ON EACH LINE). In the last three columns of the table rate yourself in terms of your confidence to perform the various activities. (CHECK THE APPROPRIATE BOX ON EACH LINE)

DEFINITION OF ACTIVITIES: Identification means finding and recognizing cases of child abuse and neglect after they have occurred.
Reporting means bringing to official attention cases of child abuse and neglect that have been identified.
Referral means linking families involved in child abuse and neglect with the resources they need.
Case Management means maintaining an on-going involvement with cases of child abuse and neglect throughout the duration of treatment.

		(1)	(2)	(3)	(1)	(2)	(3)
	Activity	High Degree of Knowledge	Moderate Degree of Knowledge	Little Knowledge	High Confidence	Moderate Confidence	Little Confidence
35.	Identification of Physical Abuse						
36.	Identification of Emotional Maltreatment						
37.	Identification of Sexual Abuse						
38.	Identification of Neglect						
39.	Reporting						
40.	Referral						
41.	Case Management						

In terms of your knowledge of the following topics related to child abuse and neglect, how would you rate yourself using the table below? (CHECK THE APPROPRIATE BOX ON EACH LINE)

	TOPIC AREA	(1) High Degree of Knowledge	(2) Moderate Degree of Knowledge	(3) Little Knowledge
42.	Reporting obligations of my state law			
43.	Legal Safeguards, if any, which protect me from liability			
44.	Procedures for interagency referral of child abuse and neglect			
45.	Procedures to report a case of child abuse or neglect			
46.	Legal definition of physical abuse in my jurisdiction			

How would you rate your understanding of the role the following organizations or individuals in your community actually play in regard to cases of child abuse and neglect? (CHECK THE APPROPRIATE BOX ON EACH LINE)

	ORGANIZATIONS AND INDIVIDUALS	(1) Good Understanding	(2) Moderate Understanding	(3) Little Understanding
47.	Police department			
48.	Schools			
49.	Day care centers			
50.	Mental health centers			
51.	Hospitals			
52.	Public health departments			
53.	Social service departments			
54.	Private physicians			

In terms of your confidence to perform the following activities related to a case of child abuse and neglect, how would you rate yourself using the table below? (CHECK THE APPROPRIATE BOX ON EACH LINE)

	ACTIVITY	(1) High Confidence	(2) Moderate Confidence	(3) Little Confidence
55.	To counsel an abusive (or potentially abusive) parent to accept help			
56.	To assess family needs			
57.	To develop a treatment plan			
58.	To follow through with other persons or agencies			
59.	To prepare for court and court testimony			
60.	To provide court testimony			
61.	To convey information on child abuse and neglect to others engaged in work with abused/neglected children			
62.	To discuss a case of child abuse and neglect with my colleagues			

88. Child abuse is the most common cause of death in children at which of the following ages?
    a. 1-5 months
    b. 6-12 months
    c. 13-18 months
    d. 19-24 months
    e. 24-30 months

89. The most important diagnostic finding in child abuse is:
    a. multiple fractures
    b. burns
    c. bruises
    d. multiple injuries at different stages of healing
    e. weight below 3rd percentile and height well above 3rd percentile on growth curve

90. All of the following may be signs of child abuse EXCEPT:
    a. pancreatic pseudocysts
    b. avulsion of the common bile duct
    c. retinal hemorrhage
    d. vulvar edema
    e. urethral caruncle

91. Which of the following skin lesions is NOT commonly associated with child abuse:
    a. ecchymosis
    b. laceration
    c. petechiae
    d. rope burns
    e. "glove" or "stocking" immersion burns

92. All of the following can be confused with child abuse and neglect EXCEPT:
    a. mongolian spots
    b. Von Willebrandt's Disease (hemophilia)
    c. bullous impetigo
    d. toxic epidermal necrolysis
    e. subluxation of the head of the radius

93. A six-month old infant is brought into the emergency room by his mother with the complaint that he has become fussy and irritable over the course of the day. He was apparently well yesterday, but today has not felt well. The mother says he has always been difficult to care for, "but then, so were my other 3 children." On examination the child is clean but looks somewhat undernourished. He is irritable and difficult to examine, and does not quiet down when you try to comfort him. There is a series of linear bruises on the left side of the face, and the left side of the mouth and ear are swollen. The fontanel is full but not bulging. In response to your inquiry the mother says the two-year old sister hit the baby yesterday.

At this point you would:

a. call the appropriate authorities and report the case as child abuse
b. order skull x-rays and a long-bone series
c. tell the mother you don't believe her story and accuse her of battering her child
d. spend some time talking with the mother to explore the family and social situation more fully
e. discharge the child home with instructions to the mother on how to care for the child.

94. The skull x-rays reveal minimal separation of all sutures with no fractures seen. No fractures or other evidence of bone injury are seen on the extremity films. At this point you feel it BEST to:

a. admit the child to the hospital for further observation and management
b. discharge the child home with a return visit scheduled in three days
c. tell the mother you don't believe her story and accuse her of battering her child
d. call the appropriate authorities and report the case as child abuse
e. obtain a neurosurgical consultation before proceeding further.

95. You are taking a call in an emergency room. The nurse calls to see Mr. and Mrs. Johnson who have a 7 month old baby with fever. They have been sitting in the emergency room for an hour but did not ask to be seen until the nurse approached them. The nurse tells you the baby looks very ill.

Vital signs: temp. 102^0 R.R. 64. p.r. 130
C.C. Cough and fever for 3 days
Physical examination:
Irritable infant with cough. Fontanel flat. Both tympanic membranes are red and full. Crepitant rales are present on the right anterior chest. There is an area of crepitation when the stethoscope is placed on the right chest. This is confirmed by palpation.
Lab: Chest x-ray. Infiltrate on the right lower lobe, six rib fractures on the right side.
CBC Hgb 10 gms WBC 16,800 PMNs 80 Bands 3 Lymphs 7

You ask the family about the fractured ribs and are told a 2 year old sibling dropped an evaporated milk can on the baby's chest.

The MOST appropriate action at this time is:

a. treat the child's otitis and pneumonia and send him home
b. call the police and hold the child in the emergency room
c. admit the child to the hospital
d. call the protective service agency
e. obtain an x-ray, skeletal survey for other fractures

96. Inflicted bruises occur commonly in all of the following sites EXCEPT the:

a. genitals
b. buttocks
c. upper lip
d. wrist
e. cheek

97. True statements about abdominal injuries in cases of child abuse include all of the following EXCEPT:

a. they are the most common non-accidental injuries
b. they are rarely asymptomatic
c. they may produce medical emergencies in affected children
d. they account for 20% of the deaths of children from non- accidental injury
e. Children with abdominal injuries may present with absent bowel sounds.

98. The MOST common intra-abdominal injury in non-accidental injury is:
    a. laceration or rupture of the intestines
    b. laceration or rupture of the liver or spleen
    c. intramural hematoma of the duodenum or jejunum
    d. rupture of the inferior vena cava
    e. laceration of the pancreas

99. X-ray findings strongly suggestive of non-accidental injury include all of the following EXCEPT:
    a. metaphysial fracture
    b. epiphysial separation
    c. multiple fractures of the same age
    d. multiple fractures of different ages
    e. subperiosteal calcification

100. Head shaking can result in all of the following EXCEPT:
    a. retinal detachment
    b. vitreous hemorrhages
    c. subdural hematomas
    d. Bell's palsy
    e. whiplash

101. A battered child has complained of pain and tenderness of the rib cage. Initial x-rays of the ribs are reported to show no evidence of fractures. The patient should be re-x-rayed in:
    a. 7-10 days
    b. 14 days
    c. 4 weeks
    d. never

102. A three year old child who has a swollen left arm and is suspected of having been abused should have the following x-rays:
    a. left humerus
    b. left upper extremity to include shoulder
    c. total body
    d. long bones
    e. both hands and chest

103. True statements about sexual abuse in children include all of the following EXCEPT:
    a. The emotional impact may be more important than any physical injury sustained.
    b. A clear history is difficult to obtain from the victim.
    c. The alleged perpetrator is most commonly a parent or other family member.
    d. Physical findings on the child usually establish the diagnosis of assault.
    e. Venereal disease may be a co-existing condition.

104. During the acute phase interview with the parents in a case of suspected child abuse, the physician should do the following: (More than one answer is correct.)

a. gather medical, sociological data with which to determine a course of action for intervention with the family.
b. accept and record the details of how the injury allegedly occurred.
c. elicit a confession.
d. advise the parents of their rights.
e. establish rapport for ongoing relationships with the family.

105. Historical data from abusive families include all of the following EXCEPT:

a. isolation
b. excessively high expectation of their children
c. low self esteem
d. expectation of personal failure
e. income usually below $5,000

106. The initial interview with the family member suspected of abusing a child is best handled by:

a. the police
b. the resident on call
c. the child's own doctor
d. the psychiatrist on call
e. the Protective Services doctor

107. Indicate which of the following are sound principles for conducting an acute phase interview: (More than one selection may be correct.)

a. It is advisable that the interviewer define for the parents his/her role in relation to the criminal justice system.
b. An accusatory approach to questioning is recommended in order to penetrate the defenses of the parent.
c. It is not necessary to inform parents that answers to any questions or statements they might make will be on the record.
d. The interviewer should observe the client's behavior closely for clues that information is being implied rather than stated outright.
e. It is important that the questions be formulated in language which parents can understand easily.

108. Which of the following elements of a medical history is MOST diagnostic of child abuse?

a. Parents are vague in explaining the cause of the child's injuries.
b. Dating of injuries by parent differs from clinical dating.
c. Parents delay in seeking medical care for child's injuries.
d. Parents allege that injury was inflicted by a third party.
e. Parents allege that injury was self-inflicted.

109. Please indicate the state where you see most of your patients:

_____Missouri
_____Kansas
_____Illinois
_____Iowa
_____Nebraska
_____Wisconsin
_____Minnesota
_____South Dakota
_____North Dakota
_____Other_____

110. How would you summarize the reporting obligations of your state law in cases of child abuse and neglect? (IF YOU DO NOT KNOW THE EXACT WORDING, STATE THE REPORTING OBLIGATIONS AS BEST YOU CAN USING YOUR OWN WORDS.)

a. Who must report:_____
_____
b. What must be reported:_____
_____
c. To whom must reports be made:_____
_____

111. What legal safeguards, if any, protect you from liability in such cases?

_____
_____
_____

112. What are the procedures for interagency referral of child abuse and neglect cases in your community?_____
_____
_____

113. What is the legal definition of physical abuse in your state? (IF YOU DO NOT KNOW THE EXACT WORDING, STATE THE DEFINITION AS BEST YOU CAN USING YOUR OWN WORDS.)

_____
_____
_____

114. Does your state law explicitly refer to emotional maltreatment as a reportable form of child abuse?

_____Yes
_____No
_____Don't know

Please complete the following items by checking the appropriate category:

1 - True
2 - False
9 - Don't know

115. In some states hearsay evidence is admissable in court if made by those directly involved in the case. 1 2 9

116. The physician may refuse to testify in court in a child abuse case because of the law of confidentiality between physician and patient. 1 2 9

117. The medical records of an examining physician may not be subpoened. 1 2 9

118. The physician must memorize the facts before testifying. 1 2 9

119. The physician may use x-rays and photographs in his/her testimony. 1 2 9

120. The physician, as an expert witness, may say anything s/he wishes in court regarding his/her medical opinions. 1 2 9

121. The physician may not make statements as to who injured the child. 1 2 9

122. The main legal risk for a physician involved in a child abuse case is:

a. a criminal suit for failure to report
b. a civil suit for reporting an unconfirmed case
c. a civil suit for failure to report a suspected case
d. a civil suit for breaking the parent's right to confidentiality in privileged communications.

123. The juvenile court can (more than one answer may be correct):
   a. determine guilt or innocence of accused
   b. remove the child from the home
   c. jail the parent
   d. fine the parents
   e. order that parent(s) obtain counseling or other social services

124. The physician's testimony is MAINLY needed at the:
   a. dispositional hearing
   b. temporary custody hearing
   c. review hearing
   d. adjudicatory hearing
   e. petition

125. Which of the following describe the role of criminal courts in cases of child abuse and neglect? (More than one response may be correct.)
   a. has some authority to make orders concerning the child victim
   b. may mandate social services for the defendant as terms of probation
   c. may levy fine if defendant is found guilty
   d. protects constitutional rights of parents and children
   e. may imprison a convicted defendant

126. In a criminal court the prosecution must show:
   a. preponderance of evidence
   b. evidence beyond all reasonable doubt
   c. probable cause
   d. reasonable likelihood

127. Which of the following defense attorney strategies is a medical witness likely to encounter during cross-examination? (More than one answer may be correct.)

   a. Physician may be attacked for failure to perform all medical tests needed to eliminate conclusively the possibility of natural causes for some of the child's injuries.
   b. Physician may be questioned on the degree of certainty with which s/he is able to diagnose child abuse and neglect.
   c. Physician's level of expertise in area of child abuse and neglect may be questioned.
   d. Physician may be questioned about each specific injury separately, trying to suggest that each injury, by itself, might have been accidental.
   e. Defense attorney may attempt to provoke physician to anger or defensiveness.

128. Would you say that the training you received has been very useful, of some use or not useful in meeting your needs?
(1)_____Very useful
(2)_____Of some use
(3)_____Not useful

129. To what extent did the training meet your specific needs related to child abuse and neglect which you identified in the earlier questionnaire? Would you say it has been very useful, of some use, or not useful in meeting your needs?
(1)_____Very useful
(2)_____Of some use
(3)_____Not useful

How would you rate the assistance provided by the training materials with respect to the various activities related to cases of chld abuse and neglect which are listed in the table below? (CHECK THE APPROPRIATE BOX ON EACH LINE.)

	ACTIVITY	(1) Very Useful	(2) Of some Use	(3) Not Useful
130.	Identification of Physical Abuse			
131.	Identification of Emotional Maltreatment			
132.	Identification of Neglect			
133.	Identification of Sexual Abuse			
134.	Reporting			
135.	Referral			
136.	Case Management			

How useful have you found the training materials for meeting the needs of the following racial, ethnic or cultural groups? (CHECK THE APPROPRIATE BOX ON EACH LINE.)

	GROUP	(1) Very Useful	(2) Of Some Use	(3) Not Useful	(9) Don't Know, Can't Say
137.	White				
138.	Black				
139.	Native American				
140.	Hispanic American				
141.	Asian American				
142.	Other (Specify:)				

143. Do the training materials need revisions to make them more effective for use with minority trainees or with those who work primarily with minority populations?

(1)_____Yes
(2)_____No (If No, go to question 145)

144. What revisions would you suggest?

_____
_____
_____
_____

How useful do you feel these materials are for training the following professionals:

	GROUP	(1) Very Useful	(2) Of Some Use	(3) Not Useful	(9) Don't Know Can't Say
145.	Physicians in practice				
146.	Physicians in training				
147.	PNP's/PNA's				
148.	RN's				
149.	Occupational therapists				
150.	Physical therapists				

151. How would you evaluate the way the training you received was put together? Would you say it was excellent, good, fair, or poor?

(1)_____Excellent
(2)_____Good
(3)_____Fair
(4)_____Poor

152. In your opinion, was the training too long, too short, or about right in length?

(1)_____Too long
(2)_____Too short
(3)_____About right

153. Was the level of the training too advanced, too elementary, or about right?

(1)_____Too advanced
(2)_____Too elementary
(3)_____About right

154. Were the training facilities used conducive to getting the material across?
(1)_____Yes (2)_____No (If No, Go To Question 156.)

155. What was good about the facilities?_____
_____

156. What should have been different?_____

How would you assess your opportunities for informal interaction with the trainer(s) and with other trainees? Would you say there were not enough of such chances, that there were too many, or that the number of such chances was about right?

157. Chances for Informal Contact with Trainers
(1)_____Not enough
(2)_____Too many
(3)_____About right

158. Chances for Informal Contact with Other Trainees
(1)_____Not enough
(2)_____Too many
(3)_____About right

How would you evaluate the training materials used? (PLACE AN "X" ANYWHERE ALONG EACH OF THE FOLLOWING TWO SCALES)

159. Very difficult to understand _____ Very easy to understand
|1 |2 |3 |4 |5

160. Extremely relevant to issues of child abuse and neglect _____ No relevance to issues of child abuse and neglect
|1 |2 |3 |4 |5

How would you evaluate the trainer(s)? (PLACE AN "X" ANYWHERE ALONG EACH OF THE FOLLOWING THREE SCALES.)

161. Appeared very competent in their fields, appeared to have the background and experience to deal with child abuse and neglect issues. _____ Did not appear very competent in their fields, did not appear to have the background and experience to deal with child abuse and neglect issues.
|1 |2 |3 |4 |5

162. Understood problems related to child abuse and neglect which might be encountered on a day-to-day basis. _____ Did not understand problems related to child abuse and neglect which might be encountered on a day-to-day basis.
|1 |2 |3 |4 |5

163. Interested in seeing that participants learn content of materials presented. 1 | 2 | 3 | 4 | 5 Not interested in seeing that participants learn content of materials presented.

164. Dealt fully and adequately with specific areas of requested assistance and with problems and issues raised for consideration and discussion. 1 | 2 | 3 | 4 | 5 Did not deal fully and adequately with specific areas of requested assistance and with problems and issues raised for consideration and discussion.

165. Additional comments about trainers:

_____

_____

166. Did the training include information or materials that you found especially valuable?

(1)_____Yes (2)_____No (If No, Go To Question 169)

167. What information or materials?_____

_____

168. Why was it valuable?_____

_____

169. Did the training omit information or materials that you believe should have been included?

(1)_____Yes (2)_____No (If No, Go to Question 171)

170. What information or materials?_____

_____

171. If the training program you attended should be offered again, would you recommend it to one of your colleagues?

(1)_____Yes (2)_____No (3)_____Don't know, not sure, can't say (If No, Go to Question 175)

172. How should the material be used?_____

_____

173. Would you advise any cautions on using the material?

(1)_____Yes (2)_____No (If No, Go to Question 175)

174. What cautions would you advise?_____

_____

175. Are there any changes in the format or content of the training materials that would improve it? How could the training materials be revised by NCCAN so that it would be more useful to you or your organization?

_____

_____

_____

_____

176. Do you have any comments or observations about any aspect of the training materials or the training itself? If so, please provide them on the space below:

_____

_____

_____

177. Assuming the cost of the training was about the same as similar training programs with which you are familiar, would you advise one of your colleagues to pay for this training?

(1)_____Yes (2)_____No

178. Do you feel your attitudes toward working with parents suspected of abusing or neglecting their children have changed as a result of this program?

_____Yes _____No

179. Why or why not?_____

_____

180. If yes, how?_____

_____

181. Will your practice or behavior change as a result of this course?
_____Yes _____No

182. Why or why not?_____

_____

183. If yes, how?_____

_____

If you wanted to increase the quality of medical treatment services for abusive and neglectful parents how would you rate EACH of the following in terms of importance?

1 - very much needed
2 - helpful, but not critical
3 - sometimes helpful
4 - not helpful

---

184. develop and widely disseminate standards for diagnosis and treatment..... 1 2 3 4

185. increase understanding from colleagues for those who treat child abuse..... 1 2 3 4

186. residency programs in child abuse..... 1 2 3 4

187. internships which include rotations in child abuse treatment..... 1 2 3 4

188. credits toward certification of continuing medical education..... 1 2 3 4

189. a physician hotline through which a consultant would be available to discuss specific case management by telephone..... 1 2 3 4

190. availability of consultants to come to an office or hospital to assist in patient treatment..... 1 2 3 4

191. more treatment units where patients could be referred..... 1 2 3 4

192. more and better public education about problems of child abuse..... 1 2 3 4

Please rate the methods you believe would be most helpful for continuing education for physicians in problems of child abuse and neglect.

1 - very helpful
2 - generally useful
3 - sometimes useful
4 - not helpful

193. lectures by known authorities at medical meetings 1 2 3 4

194. panel discussions by known authorities at major conference..... 1 2 3 4

195. audio cassettes for self study which physicians could purchase..... 1 2 3 4

196. videotape cassettes which could be viewed in the hospital staff room..... 1 2 3 4

197. films to be shown at hospital staff meetings..... 1 2 3 4

198. articles published in speciality journals (American Journal of Psychiatry, Journal of Pediatrics, etc.)..... 1 2 3 4

199. monographs on topics related to child abuse and neglect to be sent to all practicing physicians..... 1 2 3 4

200. continuing education courses through universities or county medical societies..... 1 2 3 4

201. digest of important articles sent to every physician..... 1 2 3 4

THANK YOU VERY MUCH FOR YOUR COOPERATION

The information you have provided will be very important to the evaluation of these materials in terms of their quality and effectiveness.

In several months, you may be contacted by telephone to answer a few follow-up questions concerning the training course and your activities in the area of child abuse and neglect. Should you happen to be selected, we will greatly appreciate your cooperation at that time.

APPENDIX H

Your Number:_____

MODULE EVALUATION FORM

TITLE:_____

	(5) Excel-lent	(4) Very Good	(3) Good	(2) Fair	(1) Poor
1. Organization of presentation	_____	_____	_____	_____	_____
2. Clarity of presentation	_____	_____	_____	_____	_____
3. Accuracy/timeliness of information	_____	_____	_____	_____	_____

Please specify any recommended corrections:_____

_____

_____

4. Did you learn anything from this presentation?

☐ YES ☐ NO

If yes, please specify_____

_____

5. Would you suggest any deletions?

☐ YES ☐ NO

If yes, please specify_____

_____

6. Would you suggest supplementation of the material presented?

☐ YES ☐ NO

If yes, please specify_____

_____

7. In my opinion this material is appropriate for use with:

___physicians in practice ___PNP/PNA'S

___residents ___RN'S

___medical students

Comments:_____

_____

8. In my opinion this material is appropriate for use with medical and health professionals working with racial/ethnic minority populations.

☐ YES ☐ NO

Comments:_____

TELEPHONE INTERVIEW FORMAT

Participant number_____

Is this a good time to talk?

(If not, what time would be convenient for us to call back?)

SINCE THE CA/N WORKSHOP:

1) Have you seen any children you suspected to be abused or neglected?

   If "yes", what, if anything, did you do differently than you might have done before attending the workshop?

   If "no", what, if anything, do you feel you would do differently than before attending the workshop?

2) Have you discussed ideas from the workshop:

   -with your colleagues? Explain:

   -with representatives of social service? Explain:

   -with representatives of legal profession? Explain:

   -with any of your patients? Explain:

   -with others? Explain:

3) Comments on value of NCCAN curriculum:

REGISTRATION FORM

159

please print

Please register me for the _____ course.
(name of city)

NAME: _____

MAILING ADDRESS: _____

☐ I would like to receive list of hotels/motels.

CITY, STATE, ZIP: _____

☐ I will need certificate of credit for AMA Physician's Recognition Award at completion of course.

TELEPHONE: _____

Complete registration form and mail it to Child Abuse/Neglect Demonstration Project, AAP, P.O. Box 1034, Evanston, IL 60204. Upon receipt of registration, you will receive specific information about the course you have selected, course resource materials and your pre-test.

PRELIMINARY PROGRAM

- **MEDICAL INDICATORS**

  Presents visual and radiologic findings frequently associated with child abuse and neglect. Deals specifically with skin trauma, internal injuries, skeletal injuries, sexual abuse, neglect, and failure to thrive.

- **DEVELOPMENT OF AN EVALUATION PLAN**

  Uses a case study as an exercise in making a differential diagnosis.

- **THE MEDICAL INTERVIEW**

  Explains the importance of initial and follow-up interviews with those suspected of abusing or neglecting a child. Outlines interview content and techniques.

- **BEHAVIOR OBSERVATION TECHNIQUES**

  Demonstrates how careful observation of the interaction between parents and children can provide important clues in cases of suspected child abuse and neglect.

- **LEGAL ASPECTS**

  Examines state reporting laws, criminal laws, and juvenile laws, with special emphasis on the physician's responsibility to report.

- **MEDICAL WITNESS IN COURT**

  Covers basic rules of evidence and court procedures. Suggests ways for physicians to prepare court testimony.

WORKSHOP SCHEDULE & TASK FORCE FACULTY

FEBRUARY 11, 1977: ST. LOUIS, MISSOURI
St. Louis Children's Hospital
- *Richard L. Dreher, MD, Kansas City*
- *Joan R. Hebeler, MD, Galveston, TX*

FEBRUARY 12, 1977: WICHITA, KANSAS
Wesley Medical Center
- *Ben Rubin, Jr., MD, Kansas City*
- *Cornelia M. Carithers, MD, Jacksonville, FL*

FEBRUARY 25, 1977: IOWA CITY, IOWA
University of Iowa College of Medicine
- *Gerald Solomons, MD, Iowa City*
- *David B. Friedman, MD, Los Angeles, CA*

MARCH 2, 1977: MAYWOOD, ILLINOIS
Loyola University Medical Center
- *John E. Allen, MD, Long Branch, NJ*
- *Eli H. Newberger, MD, Boston, MA*

MARCH 19, 1977: OMAHA, NEBRASKA
Children's Memorial Hospital
- *Matilda S. McIntire, MD, Omaha*
- *Barton D. Schmitt, MD, Denver, CO*

APRIL 22, 1977: MILWAUKEE, WISCONSIN
Milwaukee Children's Hospital
- *Phillip A. Bond, MD, Milwaukee*
- *Doris L. Wethers, MD, New York, NY*

MAY 4, 1977: MINNEAPOLIS, MINNESOTA
Children's Health Center of Minneapolis
- *Thomas L. Cress, MD, St. Cloud*
- *Susan L. Scheurer, MD, Lansing, MI*

MAY 6, 1977: FARGO, NORTH DAKOTA
Dakota Hospital
- *Lloyd M. Reiser, MD, Fargo*
- *William M. Palmer, MD, Salt Lake City, UT*

MAY 24, 1977: SIOUX FALLS, SOUTH DAKOTA
McKennan Hospital
- *Eberhard H. Heinrichs, MD, Watertown*
- *Glen S. Bartlett, MD, Hershey, PA*

January 1977

Dear Colleague:

In June 1976, the AAP was awarded a one-year grant from the National Center on Child Abuse and Neglect (NCCAN) to evaluate the medical unit of a curriculum on child abuse and neglect. This curriculum, developed through a contract between NCCAN and Urban and Rural Systems Associates (URSA) of San Francisco, was designed to train professionals from various disciplines.

The Academy proposal to evaluate these materials involves conducting a series of nine one-day workshops at selected hospitals and medical schools in District VI. Content will be drawn from the NCCAN curriculum and appropriate supplementary materials will also be used. Two pediatricians experienced in working with abused and neglected children and their families will lead each session, assisted by local resource faculty.

Several months ago you indicated interest in attending a workshop. Although there is no charge for you to participate, your registration fee is paid from grant funds. Do not register unless you plan to attend. About one month before the workshop, you will receive a packet containing a pre-test and resource materials. Participants are eligible for Category I credit for the Physician's Recognition Award of the AMA. Lunch and coffee will be provided at each workshop. Registrants will assume all other expenses.

Prompt return of the registration form will be greatly appreciated. I believe you will find these sessions stimulating and informative.

John E. Allen, M.D.

John E. Allen, MD
Chairman, Task Force for
Child Abuse Neglect Grant

Child Abuse & Neglect
Demonstration Project

CA/N Demonstration Project
Department of Educational Affairs
American Academy of Pediatrics
P.O. Box 1034
Evanston, IL 60204

Demonstration Project In Child Abuse and Neglect

GRANT 90-C-866
National Center on Child Abuse and Neglect
Children's Bureau
Office of Child Development
Department of Health, Education & Welfare

Evaluated by
AMERICAN ACADEMY OF PEDIATRICS

PROPOSAL FOR COMPETING EXTENSION GRANT OF OHD 90-C-866 PROFESSIONAL CONTINUING EDUCATION DEMONSTRATION PROJECT ON CHILD ABUSE AND NEGLECT

Purpose

This proposal describes a one-year project to develop a curriculum on child abuse and neglect which is approved by the American Academy of Pediatrics (AAP) for the training of health professionals. The curriculum will provide a sound basis for a one-day course to be conducted at the local level. It will consist of materials selected from those currently available and will include development of materials in designated content areas where none presently exist. The project will not undertake development of wholly new audio-visual materials, although it will standardize the audio-visuals included as to the equipment required.

Background

The AAP has long recognized abuse and neglect as one of the major unsolved health problems of children. Numerous articles have been published in its journal, Pediatrics. In 1966 and 1972 the Committee on the Infant and Preschool Child drafted statements on the problem. (Attachments 1 and 2) The chairman of the Subcommittee on Child Abuse and Neglect of the Committee on the Infant and Preschool Child testified at the 1973 hearings in support of PL 93-247[1], which had incorporated many of the recommendations in the Academy statements. One of the priority activities of this subcommittee had been to obtain funds for development of curriculum materials on child abuse and neglect for practicing physicians and for physicians-in-training. The committee was unable to secure funding for this purpose. However, it developed a self-instructional audio-cassette program on child abuse and neglect which has proved highly successful in training physicians and other professionals.[2]

In 1973 the AAP was awarded a grant from the DHEW Bureau of Health Services, Research, and Evaluation to conduct a descriptive study of nine health-based programs in child abuse and neglect.[3]

At the present time there is a great variety of training materials available on child abuse and neglect. They vary considerably in quality and in relevance to the issues faced by health professionals. To date there has been no extensive systematic review to select the best of these materials. Yet there continues to be a need for high quality training materials and for training sessions in this area.

The AAP is now completing a one-year grant from NCCAN to evaluate the effectiveness of the health unit of the multidisciplinary curriculum developed under Section 4(a)(1) of PL 93-247. The evaluation was conducted through a series of one-day workshops for Academy members in a nine-state region of the upper midwest. One additional seminar was held at the spring meeting of the Academy, which drew Fellows from across the nation. The area encompassed by the evaluation project constitutes a "project of regional scope" as defined in the priority statement for competing extension grants.

The workshop sessions were well attended by physicians. Previous experience with training in child abuse and neglect has attracted many social workers, nurses, and child protective service workers as participants, but practically no physicians. The auspices of the AAP, the provision of AMA Category I credit for course attendance, the sites selected for the workshops (local hospitals and medical schools) and the fact that the agendas were designed specifically for physicians all contributed to the unprecedented physician turnout. One of the major criticisms of the workshops was their failure always to use the best materials available. Another was the large number of different kinds of audiovisual equipment required to present the materials.

The activities of the evaluation project have focused primarily on objective #1 of the priority statement, which involves "demonstrating and evaluating the effectiveness of the curriculum". This proposal for the competing extension grant is concerned with objective #2 of that priority statement, which involves "curriculum utilization and dissemination to determine the types of training needs which may be addressed through the auspices of professional associations and the most effective and efficient approaches for meeting these needs". This proposal builds upon the experiences and activities of the Academy's previous evaluation grant by implementing to the extent possible, considering fiscal and other constraints, the recommendations contained in the final report of that demonstration project (now being prepared).

Briefly, these recommendations may be summarized as follows:

Revise scripts for the filmstrips "Internal Injuries" and "Sexual Abuse"; edit the resource papers on observing the behaviors of parents and children; and re-work the "Alice" case study materials.

Develop materials on (1) prevention and early identification of child abuse and neglect (e.g., maternal-infant bonding, identification of families in which abuse or neglect is thought likely to occur, the relationship of alcohol and drug dependency to child abuse and neglect,) (2) diagnosis of neglect and emotional maltreatment, (3) various management problems, (4) special considerations for working in child abuse and neglect with minority populations, and (5) guidelines for selecting appropriate treatment modalities to work with the family.

Scope of Work

First Quarter:

In connection with the present grant a Steering Committee (attachment 3) was formed to provide guidance on grant administration. A Tast Force (attachment 4) of eighteen pediatricians was also convened to review the NCCAN Unit 14 materials and conduct the workshop sessions. Representatives of the Steering Committee will select an interdiciplinary group of 10-15 health professionals representing organizations such as the following to develop the revised curriculum: the Task Force under the present grant, the AAP Committees on the Infant and Preschool Child and Medical Education, the Association of Medical School Pediatric Department Chairmen, the Academy of Family Practice, the American Psychiatric Association, and the American Nurse's Association. The Academy presently has formal liaison with 44 national organizations (educational, medical, social welfare, scientific, public health and consumer-oriented agencies) in addition to liaison with numerous other organizations, including state and federal government agencies, maintained through its council and committee structure.

The selected interdisciplinary group will:

(1) review training materials currently available for health professionals, selecting the best of these for inclusion or adaptation,

(2) identify content areas in which materials will be developed, considering time, fiscal, and staffing constraints,

Second Quarter:

(3) revise and/or develop the materials described in (1) and (2),

(4) review, edit, and approve the materials,

Third Quarter:

(5) field-test the curriculum (e.g., as a pilot continuing medical education course or as a seminar/round table at the Spring or Fall AAP meeting),

(6) evaluate and revise the materials as indicated by the results of the field test,

Fourth Quarter:

(7) print the curriculum materials (e.g., as articles in the AAP journal, Pediatrics; a camera-ready copy will also be provided to NCCAN at the end of the fourth quarter),

(8) disseminate announcements on the availability of the curriculum to:

a. Chairmen, medical school departments of pediatrics, family medicine, orthopedics, radiology, surgery, and osteopathic medicine;

b. Directors, schools of nursing and schools of public health;

c. County medical societies;

d. Professional medical associations;

e. Hospital directors of medical education;

f. Directors of federally-funded child abuse and neglect research and demonstration projects; and

g. Directors of federally-funded regional resource centers.

(9) recommend methods to institutionalize the curriculum - options would include offering the program as an AAP continuing medical education course, videotaping portions or all of the course for use in training, incorporating it into PACE (Professional Assessment for Continuing Education, a self-assessment exercise made available to Academy Fellows). Provision will be made for periodic revision, supplementation, and deletion of the curriculum materials.

After the grant extension period, the AAP will attempt to secure monies from a source other than NCCAN to train a pool of pediatricians in the curriculum, so that this cadre of trainers is available to local groups to conduct workshops in the manner so successfully employed in the curriculum evaluation project. Such training activities will require minimal Central Office staff time for coordination, scheduling, trainer travel expenses and honoraria, depending upon the number of sessions booked.

LSH:sm

8/1/77

FOOTNOTES

[1]Allen, J., Hearings Before the Subcommittee on Children and Youth of the Committee on Labor and Public Welfare, United States Senate: First Session on S. 1191, pp. 157-161, 1973.

[2]Committee on the Infant and Preschool Child, "A Self-Instructional Program on Child Abuse and Neglect", 1974.

[3]A Descriptive Study of Nine Health-Based Programs in Child Abuse and Neglect. Evanston, Illinois: American Academy of Pediatrics, 1974.

STATEMENT FROM MINUTES

JUNE 18-19, 1977 MEETING

AAP COUNCIL ON CHILD HEALTH

At the June 18-19 meeting of the Council on Child Health, the following motion was passed:

> The COCH endorses the principle of continuation of child abuse and neglect training for physicians and supports the efforts of the Committee on Infant and Preschool Child to seek funds for the selection of curriculum materials and training facilities.
>
> (This refers to the Infant and Preschool Committee's interest in writing a proposal for about $50,000 to present to the National Center on Child Abuse and Neglect or other agency or foundation. The proposal is for the collection of a curriculum on child abuse which could be taken to local chapters as a "traveling roadshow", using local talent plus one "expert".)

APPENDIX M:

CRITIQUE OF NCCAN
CURRICULUM MODULE 3

COMMENTS ON: "RESOURCE PAPER -

BEHAVIORAL INDICATORS OF ABUSED CHILDREN"

By Harold P. Martin, M.D.

My first concern and objection to this paper is that the author is trying to relate specific types of behaviors to whether the child has been mildly abused or severely abused. I do not believe that there is any data for this association and is a misleading conclusion. If the audience assumes, as most will, that the author is referring to the severity of medical or physiologic damage, this is even more erroneous. There is no evidence in my experience that behavioral outcomes are related to the type of injury, the severity of the physiological damage or the age of the child when abused.

The authors are correct in pointing out that children who have been abused are all not alike, but quite variable. What one truly finds is that there is an over-representation among populations of abused children of deviant behavior. One finds that abused children tend to be at one end of the spectrum or the other, so that their behavior tends to be more extreme, either extremely aggressive or extremely compliant. Perhaps this is more important than to try to relate compliancy or aggression to the consistency or the severity of physical abuse as the paper does.

The third behavior that is listed on page 3-12, "Overly Adaptive Behavior", is a category which I suggest that is less than helpful. The author is suggesting that it is overly adaptive for the child to either engage in role reversal wherein the child takes care of the needs of the parent or alternately to present as less competent and mature than the child's potential really is. In actuality, any of the behaviors one sees in the abused child can be seen as adaptive, and perhaps, even as overly adaptive. That is, the child's aggression, or his shyness, or compliancy, or even some of his lags in development such as not learning to speak can be conceptualized in my mind as adaptations of that child to a dangerous environment. Hence, I would re-write point #3 on page 3-12 to point out that one of the frequent adaptations of the abused child is to participate in a role-reversal paradigm whereby he, the child, is expected to meet the emotional and often the

physical needs of the parent. Another adaptation the child may make to the abusive environment is for the child to display dependent behavior to satisfy the needs of the parent to have a dependent child.

On point #4, page 3-12, "Lags in Development", it would be, perhaps, important to point out that many of the lags in development may be secondary to central nervous system damage, either from trauma or medical and nutritional neglect or inadequate stimulation. It is also possible that some lags in development may be an adaptation of the child to an environment where he will be in danger if he asks questions, is investigative, is curious, etc. I would agree on the third point which is made on page 3-12 that an alternative basis for developmental lags is that the child just has little energy left for development and growth because of the large amounts of energy he puts into survival.

If I were listing typical behaviors of abused children, I would include two others. I would include the fact that a large percentage of children present as very joyless children who seem to have little capacity to play, and take little enjoyment from toys, peers or their own activities. Many of these children may be truly depressed children. They have certainly not learned how to enjoy themselves and others. The sixth behavior or characteristic which I would include is the poor self-concept that the majority of abused children have. They have been in environments where there has been a repeated message either overt or covert that they are a disappointment, inadequate, bad, and it is then no wonder that they incorporate this concept of themselves internally and see themselves as bad, incompetent children.

I've commented above about my reluctance to agree with the paper which, again, starts on page 3-12 by contrasting the behavior of mildly abused versus severely abused children. There is, however, some tentative evidence that a more clear demarcation might come from considering whether the abused child has been neglected or not. Some parents have considerable interest and investment in the children they abuse. These are homes where the parents have a high investment in the child's shaping up, behaving correctly, being able to cope with the world. These parents are invested and attached to the children, but in a deviant way. It is my experience and belief that these children are less severely disturbed than a contrasting group I will mention below. At least children in this group have attention from their parents, howbeit, a deviant one.

A contrasting group of children are those abused children who are also neglected. These are the children in whom the parents have little, if any, interest or investment. These children tend to be medically neglected and are those who often demonstrate undernutrition or failure to thrive, as well as physical abuse. This is the infant or young child who is apt to be put in a room with the door closed and ignored. This child may be suffering considerably more from the effects of neglect and maternal deprivation than from any other factor in the home environment.

Finally, one might want to consider a third group of children who live in environments where the parents are severely emotionally disturbed and/or psychotic. Very often the abuse in these situations is bizarre or unusually sadistic. It should be emphasized in the paper that some of the aggressive, unpleasant behavior of these children is testing-out behavior to see what the limits are before physical retribution occurs.

It should also be pointed out in this paper that the behaviors of abused children cannot be entirely explained on the basis of the parents' dynamics. We must realize that many of the behaviors of abused children are secondary to the separations they have suffered from their parents to whom they are attached, and also, quite often, secondary to frequent changes in foster home placements they have had. Hence, we may often be dealing with children whose personalities and behaviors which are of concern to us may be more related to events that occurred after the physical abuse rather than the home environment prior to our intervention.

Starting on page 3-13, behaviors of abused children are described in different types of settings. It occurs to me that a bit more thought might be given to each of these categories. For example, under section, "Playing" on page 3-14, the point is made that children in play may act rather compulsive and be quite concerned about cleanliness and that they may also pick fights with playmates. There are other things that could be said about children's play, other than those two points. For instance, it should be said that many of these children really don't know how to play with other people and don't know how to play with toys. Much of their play in group settings, such as preschool, may tend to be more in terms of pleasing the teacher than taking any real joy out of the play activity, itself. It is a worthwhile point to make that these childrens' anger and aggression may come out with peers because it is a safe place to spill anger, while it is not safe around adults.

One final point might be made; i.e., it is not uncommon for abusive parents to reinforce "bad" behavior that they verbally complain about. If part of the dynamics of the family are that the parents see the child as an extension of the bad part of themselves or that they need to have a scapegoat in the family, they will resist the child's acting "normal" or "good". We've seen this in treatment and intervention programs where the parents sabotage attempts to help the child change his behavior, quite unwittingly. Although a parent complains of behavior "X", one sees him reinforcing that behavior as if he needs to have the child acting badly for some reasons which, for the most part, are not conscious.

In summary, I think that most of the frequent and typical behaviors of abused children have been included in this paper, but that some re-organization and reconceptualization would be helpful, as well as adding the few points mentioned above.

HAROLD P. MARTIN, M.D.
Associate Professor
of Pediatrics
University of Colorado
School of Medicine
Denver, Colorado

APPENDIX N: REVISED OUTLINE OF MATERIAL IN MODULE 6

LEGAL ASPECTS OF CHILD ABUSE AND NEGLECT

I. Type of laws involved in child abuse and neglect cases

A. Reporting standards

Every state has law which mandates reporting of suspected cases.

B. Social service rules and regulations

Dictate how departments of social services respond to a particular case.

Note: Social service laws and reporting laws are intertwined in mandatory reporting statute.

C. Criminal laws

1. Make it a crime to abuse a child (in 40% of states).
2. Remaining 60% of states may use grounds in common law (e.g., assault, manslaughter, sexual molestation) for prosecution.

D. Juvenile laws

Establish state's authority to intervene in family life. (Note: Child abuse laws are often called "dependency laws".)

II. Functions of various courts in child abuse and neglect cases

A. Criminal Court

1. Role

a. Determines guilt or innocence of accused.
   1. Has authority over defendant only, not over child.
   2. Burden of proof "beyond all reasonable doubt".
b. Determines an appropriate punishment if defendant is found guilty.
   1. Probation
   2. Fine
   3. Incarceration
c. Mandates social services
d. Protects constitutional rights of parents and children.

2. Process to initiate criminal court action

   a. Police department receives report.
   b. Police investigation
   c. Police pass report to District Attorney.
   d. District Attorney decides whether to send case to criminal court ("prosecutorial discretion").

B. Juvenile Court (in some states may be Family Court, Children's Court, or District Court with Juvenile Jurisdiction)

1. Role

   a. Jurisdiction over children (usually defined as "any person under 18 years")--protection of their interests (has no authority over parents except to motivate them in order for child to be placed back in home).
   b. Involved with following types of cases:
      1. juvenile delinquency
      2. status crimes
      3. dependency cases
   c. Provides fair and impartial review of social service agency decisions.
   d. Mandates services for family.
   (Note: Burden of proof: preponderance of evidence)
   e. Protects constitutional rights of adults and children.

2. Process

   a. Petition--initiates process; states that court has jurisdiction over child and cites reasons for court's jurisdiction according to state law.
   b. Hearings
      1. Adjudicatory--determine whether child has been abused or neglected
      2. Dispositional--determine what will happen to child. (Unless parental rights are terminated, a review is usually set for 6 months after the dispositional hearing.)
      3. Custody--in some cases, court may remove child temporarily from parents to a safe environment until permanent decision is made.

3. Attorneys involved in juvenile court

   a. County attorney (or city or corporation counsel) presents petition at adjudicatory hearing, shows that child has been abused or neglected.
   b. Attorney for parents
   c. Attorney for child (guardian ad litem) protects interests of the child.
   d. Judge (sometimes is not an attorney)

III. State Reporting Law

CURRICULUM UTILIZATION SUMMARY

*indicates audio-visual material

Workshop site	Module 1								Sup.	Module 2		Sup.	Module 3			Sup.	Module 6		Sup.	Module 7	Sup.	Other/ General	Description of Supplementary Material Used ( ) indicates in which module
	Diagnosis							Development of an Evaluation Plan		Lecture	*Medical Interview		Resource Papers	Lecture	*Vignettes		Lecture	*Issues in Reporting		"Medical Witness			(Note: The slide/tape program "visual Diagnosis of Non-Accidental Trauma and Failure to Thrive" was shown at all workshops as a replacement for the following filmstrips in Module I: "Skin Injuries" "Skeletal Injuries" "Neglect".)
	Lecture	*Skin Injuries	*Internal Injuries	*Skeletal Injuries	*Neglect	*Sexual Abuse	Alice Case Study																
St. Louis			x			x	x	x	x	x	x	x	x	x	x	x			x			(2) "Acute Phase Pediatric" "Acute Phase, Consulting Pediatrician" (3) "High Risk Family/Schizophrenic Mother"
Wichita	x					x	x	x	x	x	x		x	x	x		x			x			
Oakdale	x		x			x	x	x	x	x	x		x	x	x		x			x		x	"Don't Give up on Me"
Maywood	x		x			x		x	x	x	x		x	x			x			x			(1) Case study from trainer's experience
Omaha	x		x			x	x	x	x	x	x		x	x			x			x			
Milwaukee	x		x			x	x	x	x	x	x		x	x			x			x			
Minneapolis	x		x			x		x	x	x	x	x	x	x		x	x			x			(1) Case studies from trainer's experience (2) "Acute Phase Pediatric" "Acute Phase, Consulting Pediatrician" (3) "High Risk Family/Schizophrenic Mother"
Sioux Falls	x		x			x	x	x	x	x	x	x	x	x			x			x			(1) Case study from trainers experience (2) "Acute Phase, Pediatric" "Acute Phase, Consulting Pediatrician"
New Orleans	x		x			x		x	x	x	x	x	x	x			x			x			(2) "Acute Phase Pediatric" "Acute Phase, Consulting Pediatrician"

177

END

DEPT. OF HEW

NAT'L INSTITUTE OF EDUCATION

ERIC

DATE FILMED

SEP. 22 1978